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ABSTRACT

This newsletter issue contains 10 articles focusing on failure to thrive and the feeding of infants and toddlers with disabilities. Articles have the following titles and authors: "The Feeding Relationship" (Ellyn Satter); "Cultural Dimensions of Feeding Relationships" (Carol Brunson Phillips and Renatta M. Cooper); "Eating Well While Reading Well: Communicating Useful Nutrition Information" (Marjorie Scharf and Laurie Miller); "A Feeding Problem" (Sally Provence); "Pediatric Nutrition Practice Group: Promoting Child Health Through Optimal Nutritional Care" (Susan Krug-Wispe); "Should the Field of Early Child and Family Intervention Address Failure to Thrive?" (Peter Dawson); "Communication Strategies for Working with Parents of Infants Who Fail To Thrive" (Lynne Sturm and Dennis Drotar); "Early Start: Nutrition Services in Early Intervention in Massachusetts" (Cynthia Taft Bayerl and Jacque D. Ries); "Working Together for Breastfeeding Success" (Vergie Hughes); and "The 'Nursing-Working Dilemma': How Health professionals Can Make a Difference." Reviews of 11 related publications are also included.
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Zero to Three

Bulletin of

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The Feeding Relationship

by
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Feeding is a reciprocal process that depends on the abilities and characteristics of both the parent and the child. The child indicates an interest in being fed, with more or less clarity, and the parent responds to that interest readily, reluctantly, or not at all. Once feeding starts, the parent and child work on the process with more or less flexibility and skill. Some parents are very skillful and resourceful, and some are awkward or rigid. Children respond to their parents' limitations in a similar variety of ways. They may react positively and with adaptability of their own, or they may withdraw or scream. The parents may be accepting and supportive of a child's constitutional endowment for growth and body shape, or they may be dissatisfied and controlling.

Interactions involved in normal feeding propel an infant from a state of isolation and self-absorption to an active engagement with other people and the world (Dowling, 1977; Freud, 1946). High-quality feeding interactions during the first years of life tend to be positively linked to the child's subsequent cognitive and linguistic competence and to more secure attachments to major caregivers (Barnard, Hammond, Booth, et al., 1989). This article highlights the importance of the feeding relationship; summarizes current knowledge about the effect of feeding problems on young children's physical, social, and emotional development; and suggests both prevention and problem solving strategies.

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What is optimal feeding?

Infants have considerable capability in food regulation and eating. They are interested in eating and invested in their own survival. They instinctively suckle and take



in nourishment. They can regulate their food intake (Adair, 1984; Birch, McPhee, & Shoba, et al., 1987; Fomon, Filer, Thomas, et al., 1975; Gessel & Ilg, 1937) and grow

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in a way that reflects their genetic endowment. They naturally consume a variety of foods (Davis, 1928; Rolls, 1986). They are driven by their internal developmental processes to progress from suckling to taking semisolid foods to mastering increasingly difficult foods and eating styles (Satter, 1984). Furthermore, these capabilities are not fragile. It takes considerable interference to disrupt children's capability in food acceptance and regulation.

To manifest their eating capability (as well as to develop in other ways), however, children need appropriate supports from parents. Effective feeding requires a synchronous relationship between parent and child in which the parent's and child's behaviors are mutually contingent (Ainsworth & Bell, 1969; Broy, 1956; Satter, 1986b; Thomas, 1975). The parent must acknowledge and respect the child's capability and autonomy, but also provide the proper food, in a form the child can manage, in a social environment that is loving and accepting.

Table 1. Parent Behaviors That Support Homeostasis and Attachment

- Follow the baby's signals about what time to feed.
- Feed promptly when the baby is hungry, before the baby becomes aroused from heavy crying.
- Hold the baby so you can look at each other during feeding.
- Hold the baby securely but not restrictively.
- When using a bottle, hold it still at an appropriate angle; don't jiggle the bottle or the baby.
- Be sure the nipple flows at an appropriate speed.
- Stimulate the rooting reflex by touching the baby's cheek.
- Touch the nipple to the baby's lips and let the baby open his or her mouth before feeding.
- Let the baby decide how much to have, and at what tempo.
- Let the baby pause, rest, socialize, and go back to eating.
- Talk and smile, but don't overwhelm the baby with attention.
- Burp only if the baby seems to need it; don't disrupt feeding with unnecessary burping and wiping.
- Stop the feeding when the baby refuses the nipple or indicates satiety and lack of interest in eating by turning away, refusing to open the mouth, or arching the back.

If parents are overmanaging or insufficiently supportive, feeding as well as psychosocial development is likely to be disrupted. Unless they get positive rewards for their

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efforts, children's normal drive for development is blunted or transformed into non-productive struggles with parents.

Positive approaches to feeding allow a child to accomplish developmental tasks at any age (Satter, 1990). Feeding the newborn goes best when parents adjust their approach to the infant's timing, preference, pacing, and eating capability (Ainsworth & Bell, 1969). Such contingent interactions enhance the newborn's ability to achieve regulation of state and later firmness of attachment (Barnard et al., op. cit.). Successful regulation of state and attachment provide the groundwork for the separation-individuation phase that begins at about six months of age and that, in turn, allows for later psychosocial development. Parental feeding behaviors that support homeostasis and attachment, on the one hand, and separation and individuation, on the other, are outlined in Tables 1 and 2.

Table 2. **Behaviors That Support Separation and Individuation**

- Feed when the child wants to eat, but gradually evolve a time structure that is appropriate for everyone in the family.
- Seat the child straight up and facing forward.
- Sit directly in front of the child.
- Hold the spoon so the child can see it.
- Be engaging but not overwhelming; take care not to overload the child with talking or behavior.
- Talk in a quiet and encouraging manner.
- Wait for the child to open up and pay attention before feeding.
- Let the child touch the food and eat with fingers.
- Let the child self-feed when ready.
- When the child is self-feeding, remain present in the situation, but don't take over.
- Let the child decide how fast to eat.
- Let the child decide how much to eat.
- Respect the child's food preferences.
- Respect the child's caution about new foods.
- Remember, all children learn to eat eventually.

Feeding requires a division of responsibility between parent and child. The parent is responsible for what the child is offered to eat, the child is responsible for how much (Satter, 1987). Parents must provide an appropriate milk feeding (Committee on Nutrition, American Academy of Pediatrics (AAP), 1976), but they must allow the infant to regulate the amounts. Parents must offer solid foods in response to signs of developmental readiness

Editor's note:

This issue of *Zero to Three* owes its existence to **Peter Dawson**, a graduate National Center Fellow who teaches at the University of Colorado School of Medicine and practices at the People's Clinic in Boulder, Colorado. Dr. Dawson's longstanding interest in failure to thrive led him to organize a symposium on the subject at NCCIP's 1991 National Training Institute. To bring information on failure to thrive to a wider audience, he agreed to help plan an issue of *Zero to Three* and to undertake a comprehensive review of the literature that would help answer a timely question: Should the infants and toddlers with failure to thrive and their families be served by early intervention programs?

We soon realized that to be most useful, an issue of *Zero to Three* should explore many dimensions of what **Ellyn Satter** calls "the feeding relationship." In her own essay, Satter provides an overview of the feeding relationship in the earliest years.

Once we began to pay attention to the feeding relationship between a parent and an infant, we recognized the existence of a host of other "feeding relationships," involving infants, parents, friends and family, professionals, and even policymakers. So we asked for contributions to this issue of *Zero to Three* from authors who explore a variety of relationships that influence how a baby's need for nurturance is understood and responded to.

Just as **Marjorie Scharf** and **Laurie Miller**, for example, tell us how they communicate nutrition information to pregnant teens by focusing on "people and food in real life settings," so all the contributors to this issue show how nutrition information and services belong in the wide array of "real life settings" that serve infants, toddlers, and their families.

To all the contributors to this intellectual feast, thank you for nurturing your colleagues so generously. To readers, bon appetit!

(Committee on Nutrition, AAP, 1980), but they must let their child take the initiative in accepting foods.

Parents must provide the toddler with appropriate food and feeding structure and limit negative behaviors during meals, while at the same time allowing the child to decide how much and whether to eat (Satter, 1987). Such structure and limits are essential if children are to mature in food acceptance and learn the social behaviors associated with eating.

The patterns established in the toddler period build an essential framework for eating that persists throughout childhood. Children need the support of regular and reliable meals and snacks, and they need the limits of not being allowed to beg for food handouts or dictate the family menu. With eating, as with other interactions between parent and child, it is frightening for children

when parents fail to provide them with structure and discipline.

Feeding problems

Feeding problems represent and impinge on the quality of parent-child interactions. Problems with feeding have been variously categorized, depending on whether a child is full term and developing typically or suffers from gestational or organic limitations (Christopherson & Hall, 1978; Dahl, 1987; Dahl & Kristiansson, 1987; Gisel & Patrick, 1988; Linscheid, 1986; Tuckman, 1988; Woolston, 1983). It is estimated that 1 to 2 percent of infants and children suffer severe and prolonged feeding problems that impinge on growth (Dahl, 1987), and that 25 to 33 percent exhibit more common difficulties such as food refusal and "overeating" (Linscheid, 1985).

Children may show poor growth or nonorganic failure to thrive (NOFTT) (Linscheid, 1985), reactive or developmental (also called progressive) obesity (Mellin, 1982), colic (Taubman, 1984), stressful or intensely conflicted feedings (Satter, 1986b), poor food acceptance, refusal (Dahl, 1987) or inability to eat (Gisel & Patrick, 1988; Morris, 1989), unpleasant mealtime behaviors and failure to progress to appropriately mature eating styles (Satter, 1986b), and psychosomatic conditions such as cyclical vomiting, diarrhea, and rumination (Lourie, 1955).

Feeding problems established early in life can persist and generalize into other areas. Barnard and her colleagues (1989) found that mothers whose feeding interactions were less responsive to their child's signals had infants who were less securely attached later in life. The persistence of early feeding problems has been noted in other research, as well. Feeding interactions in the early months are replicated in play interactions after the first year (Ainsworth & Bell, 1969). Significantly higher frequencies of infections and behavior problems are found among two-year-old children who had early feeding problems (Dahl & Kristiansson, 1987). Two- to seven-year old children with feeding difficulties are more fearful and aggressive and have more toileting problems (Pelchat & Pliner, 1986). Most severely disturbed children show eating abnormalities (Stroh, Robinson, & Stroh, 1986).

Struggles around feeding interfere with a child's ability to eat a variety of food, regulate body weight, and achieve appropriate growth. When parents introduce solids too early, before the child shows signs of developmental readiness, the child and the parents struggle over eating, and the child shows poor acceptance of solid food (Beal, 1957).

Toddlers are naturally phobic about new foods (neophobic), but accept most foods with repeated neutral exposure (Birch & Marlin, 1982). Toddlers and preschoolers are less accepting of new foods when they are rewarded or otherwise pressured to eat them (Birch, Marlin, & Rotter, 1984), but more accepting when they get social support at eating time (Birch, Zimmerman, & Hind, 1980). A study of children ages two through seven years found that those with problematic eating had less exposure to novel foods, were likely to be prodded and rewarded for eating and punished for not eating, and

were likely to have developed conditioned taste aversions (Pelchat & Pliner, 1986).

Infants eat less well when parents are overactive and overmanaging in feeding, and best when parents calm them and feed them in a smooth and continuous fashion (Ainsworth & Bell, 1969; Brody, 1956; Crow, Fawcett, & Wright, 1980; Pollitt & Wirtz, 1981). It has been observed that parents of slowly growing children terminated feeding at pauses in feeding rather than after checking for satiety (Whitten, Pettit, & Fischhoff, 1969), and that when parents fed in an arbitrary or peremptory fashion, children were too thin or too fat (Ainsworth & Bell, 1969; Klesges, Malott, Boschee, et al., 1986).

Causes of feeding problems

Problems in feeding, growth, and food acceptance may stem from any or all of the following causes: 1) medical or physical condition of the child; 2) inappropriate food selection; 3) inappropriate dynamics around feeding. The first two causes have been well-treated elsewhere (Behrman, Vaughan, & Nelson, 1987; Fomon, 1974), and are commonly included as part of a diagnostic workup. Although disrupted feeding dynamics may cause problems or potentiate organic difficulties, examination of feeding dynamics is generally not routine. Of 1,120 infants with growth failure, 40 to 50 percent were found to have nonorganic etiology and/or feeding problems (Accardo, 1982). Of 2,067 laboratory tests administered to 185 children admitted to Children's Hospital in Buffalo with nonorganic failure to thrive, only 36 tests (1.4 percent) had positive diagnostic significance (Sills, n.d.). Including a feeding evaluation as a routine part of a diagnostic workup would likely eliminate the need for much unnecessary laboratory testing.

Evaluation of newborn feeding interactions can be readily accomplished using Price's AMIS scale (Price, 1983), Chatoor's Observational Scale for Mother-Infant Interaction during Feeding (Chatoor, Menvielle, Getson, & O'Donnell, 1989), or Barnard's Nursing Child Assessment Feeding Scale (Barnard, 1979). Chatoor's scale can be used to evaluate feeding dynamics in children up to three years of age. In general, interactions assessed are of the nature of those described in Tables 1 and 2. Scores of feeding dynamics correlate well with overall evaluations of parent-child interaction (Barnard et al., 1989; I. Chatoor, personal communication, 1989).

Resolving feeding problems

To resolve feeding problems, it is first necessary to determine underlying causes that put pressure on the feeding situation. At times, causes may be indirect, as one toddler's story illustrates:

When her obese grandmother died of heart disease, the parents of a robust two-year-old became hesitant to gratify her hearty appetite, for fear she would develop the same problems as her grandmother. The child, in turn, reacted to food deprivation by becoming preoccupied with food and prone to overeat whenever the opportunity presented itself. Viewing the problem as their daughter's overeating, the parents sought help in limiting her food intake.



BARBARA HADLEY

Although the parents' concern was easy to understand, looking at the problem in such a simplistic way would have increased the pressure on the child. The problem was not that she was incapable of regulating her food intake, but that her parents' grief and anxiety led them to interfere with her capability to do so.

Clearly, the history and characteristics of the child and parents interact within their environment, and both may share a history of distorted interactions and emotional dyssynchrony that continue to put pressure on the feeding situation. When the feeding relationship gets a negative start, subsequent stages may continue to be distorted as both the child and the parents carry along the feelings, behaviors, and interactions of unresolved developmental tasks. In an attempt to resolve their distress, some parents may overcompensate; others will withdraw from what has become an unsatisfying interaction.

When parents have insufficient knowledge about nutrition, feeding, and development; when they are ill; or when they have limited abilities or deficits in psychological functioning, parents may become insensitive, unsupportive, or overmanaging in the feeding relationship with their children. Conversely, children themselves can precipitate overmanaging in their parents, or exacerbate their parents' problems. This may occur when the child has functional limitations, unattractive temperamental or

physical characteristics, a labile or immature nervous system, or limited abilities to communicate. Moreover, feeding problems can be caused by environmental effects such as financial problems; a lack of situational or emotional support; a crisis in the family, job, or social network; or poor advice on feeding from friends, relatives, or professionals.

In defining and managing feeding problems, I find it helpful to use the public health model of primary, secondary, and tertiary prevention. Interventions can be constructed to: a) prevent problems by building positive feeding interactions; b) promote early detection and management; and c) provide treatment for established problems (Satter, 1990).

Primary prevention

For typically developing children. At a primary level, most feeding problems can be prevented by routine support and education about feeding and parenting in the physician's office. Parents need to learn how to establish a contingent relationship with their child around feeding, how to select appropriate food, and how to establish comfortable feeding styles. They also can be helped to become more aware of the child's eating communications and capabilities and normal growth processes.

I have described in detail and illustrated on videotape (Satter, 1989) approaches to establishing positive feeding

interactions between parents and typically developing children (Satter, 1987). Parents of children with functional problems or eating or growth idiosyncracies require anticipatory guidance to prevent feeding problems. Likewise, parents who are particularly concerned about growth, wellness, or body weight may be at risk for distorting feeding interactions and, therefore, be able to benefit from primary prevention (Lifshitz & Moses, 1989).

For children with organic deficits. Evaluation, planning, and skillful management from the onset of oral feeding difficulties allows primary prevention of feeding problems in children who have organic deficits. Complete or partial nutritional support may be maintained by nasogastric or gastrostomy tube feedings when children's energy needs outstrip their ability to ingest food. At "mealtime," parents and other care providers can interact with the child, giving partial oral feedings or, if the child is unable to feed orally, giving nipple and/or oral stimulation. This approach preserves the child's feeding skills and maintains the cognitive and emotional stimulation of the feeding interaction.

If tube feedings can be timed to coincide with the child's hunger and satiety, the feeding situation becomes even more reinforcing. Social interactions and oral stimulation are paired with the powerful relief and pleasure from satisfaction of hunger. Using this preventive approach, children with a variety of chronic illnesses and disabilities or risk factors, such as cystic fibrosis, congenital heart disease, cerebral palsy, and high-risk infants in intensive care settings—and their families—can continue to benefit from the feeding relationship.

For medical reasons, however, many children are maintained on continuous drip feedings. They never get hungry and never get full; as a consequence, they are not motivated to eat. Even when bolus feedings are initiated, these children experience difficulty recognizing and responding to hunger and satiety (K. Fox, personal communication, 1990). They must learn to pair certain feelings of discomfort with hunger and certain feelings of relief and pleasure with satiety.

It is extremely important to initiate oral motor treatment early. Even when oral feeding is not the source of nutritional support, children can receive oral stimulation during feeding that helps them begin to make the connection between what happens in the mouth and what happens in the stomach during feeding. As soon as a child is capable of sucking and can swallow a small amount without aspirating, the oral motor skills are at least partly in place for the transition to oral feeding (Morris & Klein, 1987). But once critical times for developing normal eating skills, attitudes, and interactions are missed, they are extremely difficult to reconstruct.

Furthermore, oral feeding is central to the child's normal emotional and social development (Dowling, 1977; Freud, 1946). Dowling (1977) found characteristic psychomotor deficits in otherwise healthy children with esophageal atresia who had been deprived of early nipple experiences. They lacked motivation, vitality, intentionality, and mastery and showed a lack of sustained, exuberant pleasure in their contact with the environment.

Secondary interventions

Early detection of feeding difficulties is essential to secondary prevention. Growth must be charted regularly and carefully, and minor shifts used as a basis for inquiry about feeding dynamics. If parents perceive feeding as stressful or unsatisfying, it is cause for intervention, even if growth is not affected. At a secondary level of intervention are feeding problems that appear in the context of otherwise accepting and responsive parenting. These problems are likely to yield to systematic exploration and problem-solving in the pediatrician's office. Referral to a registered dietitian can be made if more detailed instruction and problem-solving are needed. The child who eats or grows at the extreme may motivate parents to put pressure or controls on feeding. Such controls are unnecessary and even counter-productive. Fat infants don't necessarily eat too much, and thin infants don't necessarily eat too little (Rose & Mayer, 1968). Fat infants are no more likely to grow up fat than thin infants (Shapiro, 1988; Weill, 1977).

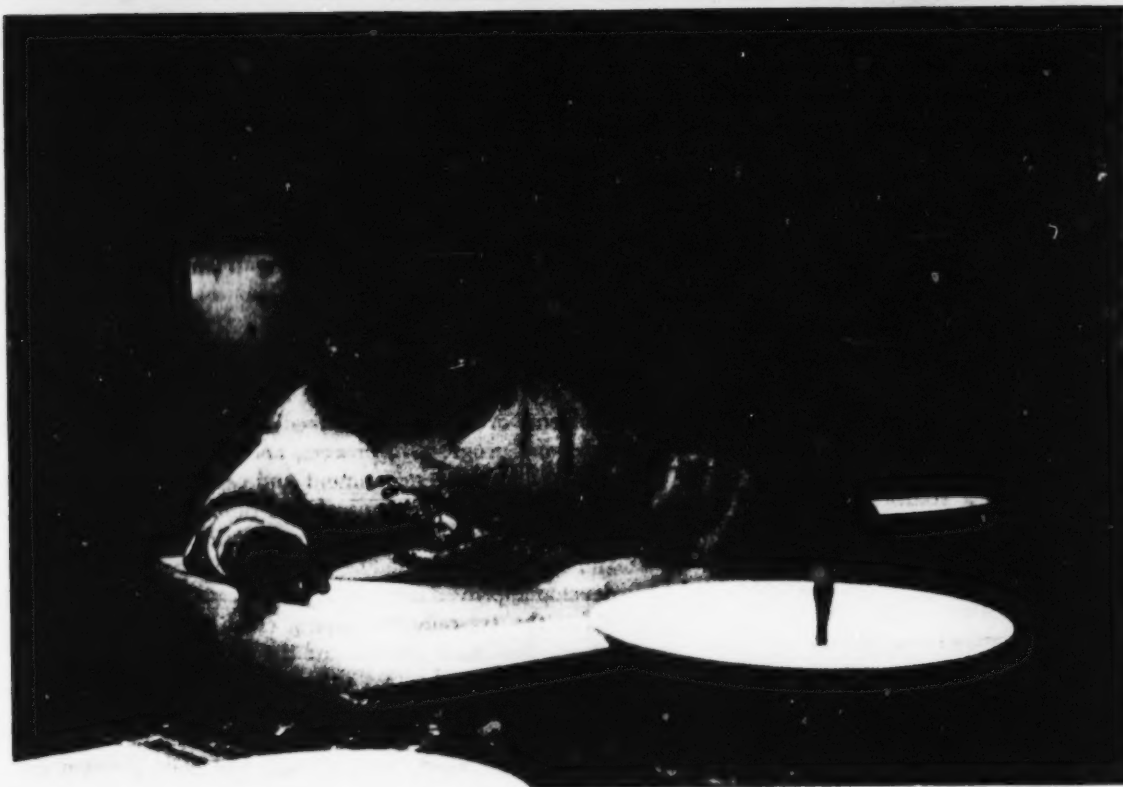
Problems at a secondary level may also grow out of particular needs or organic conditions of the child that require special handling, as evidenced by a variety of studies. Premature infants were less responsive and more disorganized than full-term infants (Magyary, 1984) and tended to develop feeding difficulties (Minde, 1984). Babies who were born small for gestational age tended to be more behaviorally compromised in feeding than babies who were born prematurely but appropriate for gestational age (Ernst, Bull, Moye, et al., 1983; Mullen, Coll, Vohr, et al., 1988). Parents of children who were perceived as at nutritional risk tended to be overactive in feeding, had difficulty achieving synchrony with their children in feeding, and showed a preponderance of forcing, overmanaging feeding tactics (Crow, Fawcett, & Wright, 1980; Field, 1977). Parents of prematurely born infants frequently failed to adapt food selection and feeding methods to the child's specialized nutritional requirements and delayed developmental cadence (Ernst, Bull, Rickard, et al., 1983).

Often, difficulty in feeding is the first sign that a child is functionally compromised. Children may demonstrate minimal neurological abnormalities, hypersensitivity, or low muscle tone. Children may also have impediments to eating, such as unidentified food sensitivities, gastroesophageal reflux, or pronounced oral hypersensitivity (Morris & Klein, 1987). If problems persist after positive feeding dynamics are instituted, it is important to look in detail at the child's physical functioning.

Tertiary interventions

At a tertiary level of intervention are well-established feeding problems. These are frequently resistant to treatment. They are characterized, at one extreme, by heightened feeling and extreme tension and rigidity or, at the other extreme, by marked remoteness, lack of concern, and absence of structure and support. Difficulties around feeding are often characteristic of other family interactions.

Tertiary problems frequently are potentiated by distorted family dynamics. I call problems at this level



PETER DAWSON

childhood eating disorders (Satter, 1986a), Minuchin and his colleagues (1975) speak of psychosomatic disorders of childhood, and Fosson and Wilson (1987) identify them as distorted family interactions surrounding the child with nonorganic failure to thrive.

Initially, many parents respond dysfunctionally to a child's illness. In time, most families cope by reorganizing to manage the crisis. Others fail to cope, reorganizing in non-productive ways around the child and the illness. Parents experiencing tertiary-level problems are likely to be so overwhelmed by processes going on outside or within themselves that they are unable to respond sensitively to their child's needs. In such instances, to be able to institute positive change, it is first necessary to bring the parent into the range of optimal functioning. To do so may require a social services referral to help the parent cope with overwhelming social and economic circumstances, or a mental health referral to help the parent deal with depression or the intense need to control (Satter, 1990).

It becomes apparent that a problem in the feeding relationship is at this level when generally helpful interventions with parenting, nutrition education, and problem solving don't work. Our experience with one child and family illustrates a tertiary-level intervention:

A 16-month-old girl would only initiate eating solid foods and drinking from a cup when she was distracted by toys. Toward the end of feedings, she ate willingly. The child had been born with neuromuscular dysfunction of the mouth and throat, and had suckled but seemed unable to swallow or retain food. When she was three

months old, she was hospitalized for failure to thrive and had a gastrostomy tube installed; she had been predominantly tube fed since that time. She had continued to use a pacifier, and had begun spoon feedings, with moderate success, at age seven months. Medical and nutritional evaluations revealed no continuing problems in those areas.

Our hypothesis was that the child was experiencing a moderate food phobia; her negative, avoidant feelings about eating were gaining supremacy over her positive approach feelings. Her parents were understandably concerned and anxious about her food intake and normal growth and development. To relieve pressure on them, we instructed her parents to continue nutritional support by gastrostomy tube, and we acquainted them with the considerable ranges and variation in food intake to be expected from a child this age. They were also helped to see the indicators that their daughter was interested and showed considerable capability in eating.

A further task was to help the child learn to manage her anxiety so she could take in food voluntarily. We suggested that the mother offer her daughter spoonfuls of food, but wait for the child's initiative before attempting to feed her. If she did not eat after a reasonable time, the mother reassured her that she didn't have to eat and she was cheerfully put down. After six meals of angry yelling, glaring at her mother, and pursing her lips, this little girl aggressively removed the spoon from her mother's hand and began to eat willingly. She continued to feed herself, although she remained easily distracted from eating.

This entire process was, understandably, extremely painful for the mother. She continued to be hypervigilant

of amounts and types of foods her daughter ate and to return to the old way of feeding when her daughter's food intake decreased below the mother's comfort level. Further exploration revealed that the attachment phase had been disrupted for this mother and child and that both were struggling with separation and individuation. These issues had to be resolved to allow feeding to develop positively.

In this example, our hypothesis of mild phobia was dictated by the girl's capability and willingness to eat and her moderately negative reaction to food. This hypothesis was substantiated by her ability to take the initiative in resolving the problem herself as soon as she was placed in a positive feeding environment with appropriate maturity demands. For some children, however, internal processes that interfere with food intake could simply be too powerful for such a solution. The child with bronchopulmonary dysplasia, whose mouth and throat have been traumatized by life-sustaining apparatus, and who also has been deprived of early eating experiences, can be extremely phobic about eating. One such child vomited when food was simply brought into the room.

Treatment

For functional families dealing with common difficulties, I have outlined a self-help approach (Satter, 1987). With secondary-level problems, the same approach can be administered by health care professionals. Also at a secondary level, Taubman (1984) describes successful treatment of colic by teaching parents to be more attentive to their infant's cues. Morris (1987) adapts acquisition of feeding skills to developmentally delayed children, while Perske and his colleagues (1986) address both the mechanics and the social/emotional issues in eating and feeding experiences for persons with severe disabilities.

Tertiary-level problems require more specialized handling. Assessment and treatment of children with feeding problems that grow out of disruption of the normal developmental processes of homeostasis, attachment, and separation-individuation have been described by Chatoor and colleagues (1986). Wright (1986) outlines multidisciplinary assessment and treatment of severely dysfunctional families, including families of children with nonorganic failure to thrive.

Other researchers have evaluated and treated children with severe behavioral distortions around eating. Their recommendations include desensitizing training for eating phobias (Linscheid, 1986), treatment of eating problems secondary to developmental delay or neuromuscular deficits (Morris, 1989), and treatment of psychosomatic problems of rumination and cyclic vomiting and diarrhea (Lourie, 1955). In each of these approaches to treatment, practitioners look for what interferes with eating mastery and work to activate the child's normal drive to eat and to achieve mastery. The child who refuses to eat may be fighting back in an overmanaging environment. The child who ruminates may be withdrawing from a non-reinforcing environment and self stimulating.

Other programs supply motivation from outside the child to initiate eating, assuming that once eating is in place it will be intrinsically motivating. I do not recommend

such programs, because they are likely to increase negative feelings about what is already a negative experience for the child. At times such programs are used when the condition is seen as life-threatening and the child and family are unresponsive to a more collaborative approach. Extrinsic motivation is used by clinicians who force children to eat (Blackman & Nelson, 1987), reward eating (Larson, Ayllon, & Barrett, 1987), or negatively reinforce food refusal, ruminating, or vomiting (Handen, Mandell, & Russo, 1986; Linscheid, 1986).

Outcome

Eating is a complex behavior with skills and attitudes that are learned slowly, over time. Treatment of eating problems or dysfunctional feeding relationships is also a slow and progressive process, and its outcome must be adjusted to the temperament and capability of the child. If necessary, other means of nutritional support—such as tube feeding—can be productively maintained to buy time and avoid proessure while the therapist, parent, and child develop improved eating skills.

For the typically developing child, if the relationship around feeding is positive and the food is appropriate, the child will eat and grow, although the amount and range of food may remain limited. For the child with neuromuscular deficits, interventions based on what the child needs and is ready for can help the child develop the capability of using the mouth for exploration and communication. Even with the most considerate, developmentally appropriate interventions, however, such children may not progress to total oral feeding (Morris, 1989).

The focus in feeding should not be on getting food into the child. Such an emphasis puts pressure on both the feeder and the child, often resulting in disrespectful feeding tactics that preempt the child's initiative. Such pressure tactics limit the child's possibility for success and instill long-term negative eating attitudes and behaviors.

Instead, the focus should be on the feeding relationship and on the achievable goal of helping the child learn eating skills and positive eating behaviors. The principle underlying all interventions is to establish a smooth and congenial feeding relationship that is appropriate for each child's developmental stage, nutritional needs, and neuromuscular development.

References

- Accardo, P. J. (1982). Growth and development: An interactional context for failure to thrive. In P. J. Accardo (Ed.), *Failure to thrive in infancy and early childhood*. Baltimore: University Park Press.
- Adair, L. S. (1984). The infant's ability to self-regulate caloric intake: A case study. *Journal of the American Dietetic Association*, 84, 543-546.
- Ainsworth, M. D. S., & Bell, S. M. (1969). Some contemporary patterns of mother-infant interaction in the feeding situation. In A. Ambrose (Ed.), *Stimulation in early infancy*. New York: Academic Press.
- Barnard, K. (1979). *Nursing child assessment feeding scale*. NCAST Publications, Mail stop WJ 10, University of Washington, Seattle, WA 98195.
- Barnard, K., Hammond, M. A., Booth, C. L., et al. (1989). Measurement and meaning of parent-child interaction. In F. Morrison, C. Lord, & D. Keating (Eds.), *Applied developmental psychology* (Vol. 3). New York: Academic Press.
- Beal, V. A. (1957). On the acceptance of solid foods and other food patterns of infants and children. *Pediatrics*, 23, 448-456.
- Behrman, R. E., Vaughan, V. C., & Nelson, W. E. (1987). *Textbook of pediatrics*. Philadelphia: W. B. Saunders.
- Birch, L. L., & Marlin, D. W. (1982). I don't like it; I never tried it:

- Effects of exposure on two-year-old children's food preferences. *Appetite*, 3, 353-360.
- Birch, L. L., Marlin, D. W., & Rotter, J. (1984). Eating as the "means" activity in a contingency: Effects on young children's food preference. *Child Development*, 55(2), 431-439.
- Birch, L. L., McPhee, L., Shoba, B. C., et al. (1987). Clean up your plate: Effects of child feeding practices on the development of intake regulation. *Learning and Motivation*, 18, 301-317.
- Birch, L. L., Zimmerman, S. I., & Hind, H. (1980). The influence of social-affective context on the formation of children's food preferences. *Child Development*, 51, 856-861.
- Blackman, J., & Nelson, C. (1987). Rapid introduction of oral feeding to tube-fed patients. *Journal of Developmental and Behavioral Pediatrics*, 8, 63-67.
- Brody, S. (1956). Patterns of behavior in feeding. In *Patterns of mothering: Maternal influence during infancy*. New York: International Universities Press.
- Chatoor, I., Dickson, L., Schaefer, S., & Egan, J. (1986). A developmental classification of feeding disorders associated with failure to thrive: Diagnosis and treatment. In D. Drotar (Ed.), *New directions in failure to thrive: Implications for research and practice*. New York: Plenum Press.
- Chatoor, I., Menvielle, E., Getson, P., & O'Donnell, R. (1989). *Observational scale for mother-infant interaction during feeding*. Washington, DC: Children's Hospital Medical Center.
- Christopherson, E. R., & Hall, C. L. (1978). Eating patterns and associated problems encountered in normal children. *Issues in Comprehensive Pediatric Nursing*, 3, 1-16.
- Committee on Nutrition, American Academy of Pediatrics (AAP). (1976). Commentary on breast-feeding and infant formulas, including proposed standards for formulas. *Pediatrics*, 57, 278-285.
- Committee on Nutrition, AAP. (1980). On the feeding of supplemental food to infants. *Pediatrics*, 65, 1178-1181.
- Crow, R. A., Fawcett, J. N., & Wright, P. (1980). Maternal behavior during breast- and bottle-feeding. *Journal of Behavioral Medicine*, 3, 259-277.
- Dahl, M. (1987). Early feeding problems in an affluent society. III. Follow-up at two years: Natural course, health, behavior and development. *Acta Paediatrica Scandinavica*, 76, 872-880.
- Dahl, M., & Kristiansson, B. (1987). Early feeding problem in an affluent society. IV. Impact on growth up to two years of age. *Acta Paediatrica Scandinavica*, 76, 884-888.
- Davis, C. M. (1928). Self selection of diet by newly weaned infants. *American Journal of Diseases of Children*, 36, 651-679.
- Dowling, S. (1977). Seven infants with esophageal atresia—a developmental study. *Psychoanalytic Study of Childhood*, 32, 215-256.
- Ernst, J. A., Bull, M. J., Moye L., et al. (1983). Growth outcome of the very low-birth-weight infant at one year. *Journal of the American Dietetic Association*, 82, 44-49.
- Ernst, J. A., Bull, M. J., Rickard, K. A., et al. (1983). Feeding practices of the very low-birth-weight infant within the first year. *Journal of the American Dietetic Association*, 82, 158-162.
- Field, T. (1977). Maternal stimulation during infant feeding. *Developmental Psychology*, 13, 539-540.
- Fomon, S. J. (1974). *Infant nutrition* (2nd ed.). Philadelphia: W. B. Saunders.
- Fomon, S. J., Filer, L. J., Thomas, L. J., et al. (1975). Influence of formula concentration on caloric intake and growth of normal infants. *Acta Paediatrica Scandinavica*, 64, 172-181.
- Fosson, A., & Wilson, J. (1987). Family interactions surrounding feedings of infants with nonorganic failure to thrive. *Clinical Pediatrics*, 26, 518-523.
- Freud, A. (1946). The psychoanalytic study of infantile feeding disturbances. *Psychoanalytic Study of Childhood*, 2, 119-132.
- Gessel, A., & Ilg, F. L. (1937). *Feeding behavior of infants*. Philadelphia: J. B. Lippincott.
- Gisel, E. G., & Patrick, J. (1988). Identification of children with cerebral palsy unable to maintain a normal nutritional state. *Lancet*, 1, 283-286.
- Handen, B. L., Mandell, F., & Russo, D. C. (1986). Feeding induction in children who refuse to eat. *American Journal of Diseases of Children*, 140, 52-54.
- Klesges, R. C., Malott, J. M., Boschee, P. F., & Weber, J. M. (1986). The effects of parental influences on children's food intake, physical activity, and relative weight. *International Journal of Eating Disorders*, 5, 335-346.
- Larson, K. L., Ayllon, T., & Barrett, D. H. (1987). A behavioral feeding program for failure-to-thrive infants. *Behavioral Research and Therapy*, 25, 39-47.
- Lifshitz, F., & Moses, N. (1989). A complication of dietary treatment of hypercholesterolemia. *American Journal of Disorders of Children*, 143, 537-542.
- Linscheid, T. R. (1985). Feeding disorders during infancy and early childhood. *Feelings and Their Medical Significance*, 27(3). Columbus, OH: Ross Laboratories.
- Linscheid, T. R. (1986). Disturbances of eating and feeding. In D. Drotar (Ed.), *New directions in failure to thrive: Implications for research and practice*. New York: Plenum Press.
- Lourie, R. S. (1955). Treatment of psychosomatic problems in infants. *Clinical Proceedings of Children's Hospital of the District of Columbia*, 11(19), 142-152.
- Magyary, C. (1984). Early social interactions: Preterm infant-parent dyads. *Issues in Comprehensive Pediatric Nursing*, 7, 233-254.
- Mellin, L. (1982). Evidence of reactive obesity in adolescent females. Paper presented at the annual meeting of the Society of Adolescent Medicine, New York.
- Minde, K. K. (1984). The impact of prematurity on the later behavior of children and on their families. *Clinical Perinatology*, 11, 227-244.
- Minuchin, S., Baker, L., Rosman, B. L., et al. (1975). A conceptual model of psychosomatic illness in children: Family organization and family therapy. *Archives of General Psychiatry*, 32, 1031-1038.
- Morris, S. E. (1989). Development of oral-motor skills in the neurologically impaired child receiving non-oral feedings. *Dysphagia*, 3, 135-154.
- Morris, S. E., & Klein, M. D. (1987). *Pre-feeding skills: A comprehensive resource for feeding development*. Tucson: Therapy Skill-Builders.
- Mullen, M. K., Coll, C. G., Vohr, B. R., et al. (1988). Mother-infant feeding interaction in full-term small-for-gestational-age infants. *Journal of Pediatrics*, 112, 143-148.
- Oates, R. K., Peacock, A., & Forrest, D. (1985). Long-term effects of nonorganic failure to thrive. *Pediatrics*, 75, 36-40.
- Pelchat, M. L., & Pliner, P. (1986). Antecedents and correlates of feeding problems in young children. *Journal of Nutrition Education*, 7, 333-342.
- Perske, R., Clifton, A., McLean, B. M., & Stein, J. I. (1986). *Mealtimes for persons with severe handicaps*. Baltimore: Paul H. Brooks.
- Pollitt, E., & Wirtz, S. (1981). Mother-infant feeding interaction and weight gain in the first month of life. *Journal of the American Dietetic Association*, 78, 596-601.
- Price, G. M. (1983). Sensitivity in mother-infant interactions: The AMIS Scale. *Infant Behavior and Development*, 6, 353-360.
- Rolls, B. J. (1986). Sensory-specific satiety. *Nutrition Review*, 44, 93-101.
- Rose, H. E., & Mayer, J. (1968). Activity, calorie intake, fat storage and the energy balance of infants. *Pediatrics*, 41, 18.
- Satter, E. M. (1984). Developmental guidelines for feeding infants and young children. *Food and Nutrition News*, National Live Stock and Meat Board, 56(4), 21-26.
- Satter, E. M. (1986a). Childhood eating disorders. *Journal of the American Dietetic Association*, 86, 357-361.
- Satter, E. M. (1986b). The feeding relationship. *Journal of the American Dietetic Association*, 86, 352-356.
- Satter, E. M. (1987). *How to get your kid to eat—But not too much*. Palo Alto, CA: Bull Publishing.
- Satter, E. M. (1989). *Feeding with love and good sense* (videotape). Palo Alto, CA: Bull Publishing.
- Satter, E. M. (1990). The feeding relationship: Problems and interventions. *Journal of Pediatrics*, 117(2/2), 181-189.
- Shapiro, L. R. (1988). Verbal report. In J. Ikeda *Children and weight: What health professionals can do about it*. Berkeley: University of California Extension.
- Sills, R. H. (n.d.). Failure to thrive: The role of clinical and laboratory evaluation. *American Journal of Diseases of Children*, 132, 967-969.
- Stroh, K., Robinson, T., & Stroh, G. (1986). A therapeutic feeding programme. I. Theory and practice of feeding. *Developments in Medicine and Child Neurology*, 28, 3-10.
- Taubman, B. (1984). Clinical trial of the treatment of colic by modification of parent child interaction. *Pediatrics*, 74, 998-1003.
- Thoman, E. V. (1975). Development of synchrony in mother-infant interaction in feeding and other situations. *Fed Proc*, 34, 1586-1592.
- Tuckman, D. (1988). Dysfunctional swallowing in the pediatric patient: Clinical considerations. *Dysphagia*, 2, 203-208.
- Weil, W. B. (1977). Current controversies in childhood obesity. *Journal of Pediatrics*, 91, 175-187.
- Whitten, C. F., Pettit, M. G., & Fischhoff, J. (1969). Evidence that growth failure from maternal deprivation is secondary to underfeeding. *Journal of the American Medical Association*, 209, 1675-1682.
- Woolston, J. L. (1983). Eating disorders in infancy and early childhood. *Journal of the American Academy of Child Psychiatry*, 22, 114-121.
- Wright, B. M. (1986). An approach to infant-parent psychotherapy. *Infant Mental Health Journal*, 7, 247-263.

Cultural Dimensions of Feeding Relationships

by

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My husband and I prepare the food that our children (Chloe, 3 years; John, 5 months) get. We cook it ourselves, using as little processed foods as possible. We put food out that we feel is balanced, and Yolanda feeds them when we are not here. It's pretty clear what they can have, and we don't get uptight about the amount they eat on a day-to-day basis. My pediatrician said not to be uptight about what they eat—they will eat a balanced diet, but may not eat a balanced meal ...

(When I was a child) the food was laid out in traditional Chinese style, and we used chop sticks and spoons. Meals were very formal, no one was allowed to touch anything until everyone was seated. It was the time of day when we all connected ...

... I don't know any woman who doesn't breastfeed ...

—Joy Lee*, Chinese American, professional, age 39

One of my nipples wouldn't come out, and the baby just went to sleep when I was trying to feed her. The nurse suggested that I just give her formula, and my Mom said that it would be okay too, so I did. It makes it easier for other people to feed her ...

... She's been receiving solids since she was two months old. I just wanted to see if she would sleep better. The doctor said she didn't need any solids for a year, but my Mom and I decided that if we gave her cereal at night, that she would sleep through the night ... I want to be the one to introduce new foods to her so I can see what she likes and dislikes.

—Michelle Scott, African American, clerical worker, age 20

I was always inclined toward self feeding ... I'd rather clean up the mess than have a battle over eating. I've seen other parents who feed their children, and they're still sitting next to them when they're five—making sure that they eat. I've never wanted that. To be relaxed about meals was natural for me ...

When others feed my kids, it's important that they feel in charge. I want them to feel comfortable. I hire people that I'm comfortable with, and it's okay if their style is different ...

—Linda Levy, European American (Jewish), upper middle class mother at home, age 36

At first, spilling food worried me a lot (because of the mess). I just wasn't raised that way.

—Alex Levy, European American (Jewish), entrepreneur, age 41

*names of respondents and their families have been changed

It works best to hire staff who have children of their own it gives them something to draw on. Those people with 12 early childhood credits and no practical experience don't have the patience that it takes to work with these children day in and day out ... Some of the staff put cereal in these babies' bottles. I know that they shouldn't do it—but it gets frustrating feeding these kids. Sometimes you just want to make sure that they've had enough.

—Clara Davis, African American, site director of a group home for infants and toddlers who have been affected by their mothers' drug use, age 50+

These observations on feeding babies and young children were made by parents and caregivers of infants and toddlers, interviewed in California early in 1992. Asked to comment on cultural dimensions of the feeding relationship for this issue of *Zero to Three*, we thought about aspects of culture that play a significant role in how children are fed. As we talked to parents as a way to begin our thinking, we were reminded that given the intricate combinations of race, ethnicity, educational level, and class that contribute to our country's diversity, isolating culture is a complex endeavor.

As students of the role of culture in child development, we realized that the parents we talked to were indeed revealing cultural influences from their own families. Yet these parents and caregivers were also revealing their response to American "child development" traditions. In this tradition, professional credentials confer authority (It is permissible for a parent to be relaxed about a toddler's food intake if the pediatrician tells her "not to be uptight.") Even professionals with relatively low status in the larger world, such as nursing assistants and child care providers, have tremendous power in early feeding relationships: They facilitate breastfeeding, or don't; they elicit and accommodate individual parents' feeding preferences or create a culture of group care; they follow parent/employers' instructions to the letter or develop their own unique feeding relationship with the baby in their care.

At the same time, we have long been aware that "child development tradition" itself is full of pervasive ethnocentrism, exhibited in the professional literature as well as among practitioners. Much of what we know as "child development" is the product of a predominantly North American/European scientific endeavor and tradition, resulting in a narrow database (Nugent et al., 1986). Although there is a growing awareness that empirical findings reported in the literature cannot be generalized to most of the world's children today, we frequently find descriptions of children that nonetheless make assumptions about "normal development" from a Eurocentric perspective. And assumptions about "normal development" quickly become, of course, the foundation for ideas about what is "developmentally appropriate" practice.

Take the issue of self feeding among infants and toddlers, for example. The experts (Leach, Spock) tell us that it is important to encourage babies to take part in the feeding process, even though a mess results. Child care providers who are sensitive to the demands on



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families may not urge parents to allow messy self feeding attempts at home. But true to the tradition of "child development," these professional caregivers will make sure that there is time for children to learn self-feeding skills in the child care setting. The adults will clean up the mess. The children will move toward sturdy independence.

But what if early independence turns out not to be valued by a family? Consuelo Aquino (in Clark, 1981, cited in Cortez & Young-Holt, in press) writes:

(In my culture) the baby is considered a very precious thing. As the baby grows he is watched closely with loving concern. Expectations are kept below the child's potential . . . all problems are met indirectly by distracting and pacifying the child. This leisurely maturation process influences the mother's action in feeding . . . Children tend to be dependent, but this is an accepted norm within the culture.

How do we recognize and resolve such dilemmas, when the vast and growing diversity of the families we serve may make the potential for dilemmas seem endless? It is our belief that the best guide for our daily work with children and families is a process approach rather than a recipe, and that such an approach requires us to understand the "deep structure" of culture (Phillips, in press). But first, let us consider some basic concepts about development and culture.

Development within a cultural matrix

We have learned to understand development as a function of the *interrelationships* between the human organism and the environment. The behavioral and developmental capabilities of newborns are modified over time as they make adaptations within the cultural matrix to which they are exposed. At the same time, newborns influence or *shape* their caregivers' responses and, thus, their own caregiving environment. These relationships both promote and limit what we call development.

In this complex process, culture is the mechanism for containing and transmitting the rules for behavior that make it possible for children to participate in a shared meaning system. It is through this participation that children come to have power in the world. Babies, for example, are born with the biological capacity to produce sound; yet not until they come to know the rules that govern speech and language in their culture do they gain the power to communicate. Babies are born with the biological capability to organize information, yet not until they acquire the shared meanings for objects and events do they gain the *power to reason*. As children become more proficient with the rules governing their world, they become more powerful instruments in their own developmental process.

For infants, this process is realized even in the course of normal, daily routines—like feeding. This activity, while serving a nutritional function, also serves to transmit ideas—not just idiosyncratic ones but *patterns of meaning* that are shared by and embodied in the lifestyles of a larger group.

While broad variations in these patterns between cultures are of interest, as critical to our concern here are the enormous subtleties of this process. The quotations at the beginning of this essay suggest that in addition to race and ethnicity, parents' age, education, and social class play a significant role in how children are fed. To understand fully the layers of meaning surrounding any feeding issue, we need to know about family patterns (maternal and paternal) going back at least a generation. We need to be aware of a host of power/control questions, including whether one parent defers to another in matters of feeding, whom parents regard as ultimate authorities on infant feeding, and parents' feelings about delegating control of children's feeding to other adults.

We can only speculate, for example, about why the traditionally raised Chinese American "thirtysomething" professional quotes her pediatrician's advice not to get "uptight" about what her young children eat at a given meal. Does this have something to do with Chinese respect for professional learning? Does it reflect the tendency of professionals to credit their colleague's expertise in his specialty? Would this mother quote the advice of a pediatrician whose recommendations ran counter to her own instincts? And what do the grandparents think?

Michelle, the young African American mother, tells us clearly that her own mother's influence far outweighs any recommendation that a pediatrician might make about feeding her new baby. This twenty-year-old still lives at

home, and even though Morgan is clearly her child, Michelle appreciates her mother's guidance and support. Michelle had initially planned to breastfeed her daughter, although she reported that most of her friends never even think about breastfeeding. The minor problems she experienced are not unusual, nor is it rare for a newborn to be uninterested in eating. What would have happened if nursing staff or Michelle's mother had given her this information, or encouraged her to persist in breast-feeding?

If Linda Levy's relaxed attitudes about feeding are becoming typical in her subculture, a whole line of "Jewish mother" jokes will be meaningless within a generation.

Residential group care of drug-affected infants may, unfortunately, be emerging as a new subculture in our society. We can observe "cultural rules" being articulated by Mrs. Davis. She says, for example, that it is best to hire staff who have children of their own ("It gives them something to draw on as they work with these children.") She also prefers hiring African American women, since they often "feel like they are giving something back to the community" and this translates into a more stable staffing pattern. Training for staff is not mandated by the state, but is left to each group home owner/operator. In the home run by Mrs. Davis, staff interactions with children are based on their own parenting style. We observed, for example, that a child who could feed himself with his fingers was discouraged from doing so by staff who preferred him to use a spoon, which he could not manage easily. His eating was disrupted by the resulting confrontations. Interaction between two boys being fed at the same time was not encouraged. In fact, if staff had viewed interaction as interfering with the children's eating, they would probably have actively discouraged it.

Feeding is, of course, only one aspect of nurturing. In fact, the notion of infant "feedings" as distinct phenomena may itself be culture-bound. In their study of maternal sensitivity among Laotian Hmong immigrants to the United States, for example, Muret-Wagstaff and Moore observed that Hmong mothers feed their infants almost continuously (as opposed to on a schedule). They express affection by nuzzling (as opposed to kissing and stroking); they greet babies with vocalization and smiles, waiting for a response and imitating, (as opposed to actively seeking vocal face-to-face interactions—alternately stimulating and soothing precisely in tune with the baby's state of arousal [Muret-Wagstaff & Moore, 1989].) These observations suggest the intricacies with which mothers, by reinforcing certain behaviors and ignoring others, communicate to their children the Hmong way of being in the world, and in turn the subtle ways babies learn to shape their interactions and impact in it. One can only marvel at the complexity of these exchanges and wonder about their meaning.

Subtleties of interaction within relationships make up the developmental process, and the empowering elements in relationships are precisely what we want to ensure for children. As practitioners, we must become better at understanding cultural messages in order to ensure their continuity, provide for their consistency and intervene

to prevent any potential disruptions in the process. But how?

Principles for observing dimensions of culture

In the absence of a mature body of literature to guide our practice, we must become better observers ourselves. We must use our day to day work with children to sharpen our understanding about culture. This starts with knowing *what* to look for and *how* to discuss what we see. Having a good technical definition of culture might help, but it is not as necessary to our practice as having a general sense about culture as a force.

Described below are six important concepts that have been helpful in our own struggles to understand the "deep structure" of culture (Phillips, in press). They are dimensions of culture that are most commonly misunderstood. Awareness of them helps facilitate our ability to observe human behavior and to discuss what we see.

1. *Culture is a set of rules for behavior. (We tend to think of culture as something concrete.)* You cannot "see" culture because you cannot see rules; you can only see the products of culture, in the sense that you can see the behaviors the rules produce. Yet, cultural rules do not cause behavior, they influence people to behave similarly, in ways which help them to understand each other.

It is by understanding your culture's rules that you know how to greet a person younger than you, older than you, a friend, a stranger. Cultural rules help you to know *how* to hold a baby. Cultural rules shape food preferences, and celebrations—govern whether you celebrate the sun or the moon; whether you wear a dress or pants, or nothing at all. These rules give meaning to all the events and experiences of life. The essence of culture is not these behaviors themselves, but the rules that produce the behaviors.

2. *Culture is characteristic of groups. (We tend to think of culture mainly in terms of how it affects the individual.)* The rules of a culture are shared by the group, not invented by the individual; the rules of the group which are passed on from one generation to the next form the core of the culture. It is a mistake to confuse individual differences with group cultural differences. Every person develops a unique personality as a result of her or his personal history, yet at the same time develops within a cultural context with some behavioral characteristics which are shared with other members of the group. The things we have in common with all humans are the universal, how we differ one from another are the individual, and what we share with members of our group are the cultural.

3. *Culture is learned. (Culture is sometimes confused with race or ethnicity.)* No one is born acculturated; rather, we are born with a biological capability to learn. What each person learns depends upon the cultural rules of the people who raise them. Some rules are taught with words "hold your fork in your right hand, and your knife in your left." Other rules are demonstrated by actions—when to smile, how close to stand when talking to someone.

Because culture is learned, it is a mistake to infer a person's culture from his or her appearance. Someone

can be racially black and culturally Irish. A person can also become bi-cultural or tri-cultural by learning the rules of cultures other than his or her own primary group.

4. *Individual members of a culture are embedded to different degrees within their culture (This is the answer to someone who insists, "There's no such thing as Black culture, because all Black people aren't alike.")* Because culture is learned, it can be well learned by some people in the group and less well learned by others. As children are acculturated they usually learn the core rules of their culture, yet they may not always learn every cultural rule equally well. Some families are more tradition-oriented, others less. Further, even though families and individuals learn the cultural rules, they may not always behave according to what they have learned—some people are conformists, others are non-conformist. As a consequence of both phenomena, we say that the behavior of members of a culture will vary depending upon how deeply embedded his or her experiences are within the core of a culture. As we work with individual families, thinking about behavioral variations in this way helps us understand why for instance, all Japanese people don't always "act Japanese."

5. *Cultures borrow and share rules. (This is the answer to the question, "If cultures are different one from another, then why are we alike in some many ways?")* Every cultural group has its own set of core behavioral rules and is therefore unique; yet cultural boundaries overlap and some of the rules of Culture A may be the same as the rules of Culture B. This happens because cultural rules evolve and change over time; sometimes when two groups have extensive contact with one another, they influence each other in some areas. Thus two groups of people may speak the same language, yet have different rules about roles for women. Understanding this helps us avoid discounting the significance of culture just because a person from another culture is so much like you in some ways.

6. *Members of a cultural group may be proficient at following cultural rules but unable to describe them. (Thus the question, "Would you please tell me about your culture?" is unlikely to yield the information you need.)* Acculturation is a natural process. As we become acculturated we are not conscious that our ideas and behavior are being shaped by a unique set of rules. Just as a four-year-old who is proficient with language couldn't, if asked, diagram a sentence or explain the rules of grammar, so also do people become thoroughly proficient with cultural behavior without consciously knowing that they are behaving according to rules. Understanding acculturation in this way explains why you can't walk up to a person and ask him to teach you his culture. Nor could you probably explain your own.

Empowering young children through cultural consistency

Keeping these principles in mind will help us begin to open the dialogue within settings where children are developing. Insofar as our goal is to provide settings outside their homes that are empowering contexts for children, then the aim of this dialogue ought to be ensuring culturally consistency so their power can be transferred from one setting to the other.

To do so requires several strategies:

1. Observe parents with their own children. Find out what children are familiar with. Practice and imitate what you see. Think about your own cultural style and how it differs from other people's. Have someone watch you and tell you what they see.
2. Discuss culture and how it influences development—staff together, staff with parents, staff with experts. Create an open climate for questions and an open climate for tentative answers. Ask simple questions—what do you expect when other people feed your child? Keep the perspective that people are experts on their own lives. Be aware of power advantage you have over parents. Ask yourself, how can I become more effective in getting information from clients/patients/parents who would never disagree with me face to face? Use informants. Be reflective. De-center: become more insightful about your own culture and how it influences your own development. Don't believe everything you read. Work to identify situations where ethnocentrism is at work.
3. Be prepared for contradictions and conflict. Deal with them as they emerge. (What should you do when you believe some feeding practice contributes to health problems or cultural tradition is not "developmentally appropriate?" Are you perpetuating cultural hegemony by asking someone to change his or her culture?) Don't look for a "recipe solution." Design temporary resolutions. Study the impact of your decisions. Evaluate your progress and change your plans if they aren't working. Create a new knowledge base. Write about it. Share it with the rest of the field.

This dialogue will yield the new ideas that all of us need to understand the cultural dimensions of young children's development. Ongoing dialogue will help all concerned about the well-being of young children and their families to ensure that they will thrive in our country's cultural diversity.

References

- Aquino, Consuelo, J.R.N., M.P.H. 1981. *The Filipino in America. Culture and Childbearing*. Ann L. Clar, R.N., M.A. (ed.). Philadelphia: F.A. Davis Company.
- Muret-Wagstaff, Sharon, and Shirley G. Moore "The Hmong in America: Infant Behavior and Practices" in Nugent, J. Kevin, Barry Lester and T. Berry Brazelton, editors (1989). *The Cultural Context of Infancy, Volume one: Biology, Culture, and Infant Development*. Ablex Publishing Corporation, Norwood, NJ. pp 319-340.
- Nugent, J. Kevin, Barry Lester and T. Berry Brazelton, editors (1989). *The Cultural Context of Infancy, Volume one: Biology, Culture, and Infant Development*. Ablex Publishing Corporation, Norwood, NJ.
- Phillips, Carol Brunson (1992) "The promises of diversity: Multicultural challenges and opportunities." *National Louis University Bulletin*, Volume 10, No 1. Evanston, IL. pp 1-2.
- Phillips, Carol Brunson (in press) "Culture: a process that empowers" in *Infant/Toddler Caregiving: A guide to Culturally Sensitive Care*, Jesus Cortez and Carol Lou Young-Holt, editors. Far West Laboratory for Educational Research and Development, Sausalito, CA. pp. 2-9.
- Phillips, Carol Brunson (1988) "Nurturing diversity for today's children and tomorrow's leaders." *Young Children*, Volume 43, No 2. Washington, DC. pp. 42-47.

Eating Well While Reading Well: Communicating Useful Nutrition Information

by
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and
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Pregnant women and teens are often overwhelmed with information and advice from family, friends, and health care providers. Although well-intentioned, this advice may be a confusing and inconsistent jumble, failing to address the needs and concerns of the pregnant teen. As a result, an individual will be unable to follow any advice. *Healthy Foods, Healthy Baby* was developed to reach pregnant teens with practical help that they can use every day to choose meals and snacks. Through its effective use, it can help the reader make a lifelong commitment to good nutrition for herself, her baby, and her family.

The booklet differs from most nutrition education booklets in that it focuses on people and food in real life settings rather than on nutrient sources, serving sizes, or physiological explanations. This 32-page booklet portrays the story of two pregnant teenagers, Kim and Maria. It refers to family and friends who reinforce advice provided by the booklet and health care staff.

Healthy Foods, Healthy Baby was produced using a comprehensive development process to assure that the booklet is relevant, culturally appropriate and readable. We sought extensive involvement from consumers in the booklet's development through focus group discussions with pregnant teenagers. We also sought advice from front line staff who would use the booklet. We obtained technical review from health, nutrition and literacy experts, and conducted extensive pretesting of the text and illustrations with pregnant teenagers. Involving patients in the booklet's development phase was the single most important factor in creating a product which was well received and used.

This article presents an overview of strategies used to develop this tool as well as tips for writing easy-to-understand nutrition and health messages for pregnant women, new moms, family members and other care providers.

We present this nutrition booklet as a case study in hopes that service providers working with pregnant women and young families will be able to apply these strategies when evaluating and selecting existing material and when developing new materials for a culturally diverse population with low literacy skills. Since distributing "appropriate" materials is not enough, this article also suggests methods to ensure their effective use.

Writing for your audience

It is estimated that one out of five American adults reads at the fifth grade reading level or lower. A person

may not be able to read a recipe, a job or benefits application, instructions on a medicine bottle, or health education materials. He or she may have adequate intelligence but lack reading skills.

HEALTHY FOODS HEALTHY BABY



Poor readers may read slowly and skip words. Their eyes may wander aimlessly over text, lists or charts. As a result the meaning of the text is lost or jumbled. In contrast, a good reader will read for information, interpreting meaning from the words. She or he will use a pattern to search for the main idea when scanning text, lists, or charts.

Many printed nutrition education materials are written at a reading level well above the skills of those who receive them. Simple wording is important, but other qualities also make written materials difficult to read and understand.

Pointers to help improve readability:

- **Avoid extensive content:** Say only what is necessary to help someone to choose foods. A technical discussion of nutrients will not help a teen choose a snack to carry in her purse each day. Some things are nice to know, but consider first what she needs to know. In this case, give her suggestions of what snack foods she can carry

in her purse, e.g. a piece of fruit, cheese and crackers, peanut butter crackers, pretzels.

● **Use familiar words and ideas:** Use words and concepts that are familiar to your audience. Although nutritionists and other health care workers are familiar with food groups, serving sizes, and exchange lists, these concepts are less familiar or useful to consumers. A teenager who likes chicken and turkey may not realize that these are the "poultry" the nutritionist suggested. To a teenager, the roll for her hoagie or submarine sandwich is one serving of bread, while the nutritionist would consider the same roll to be four "bread exchanges."

Similarly, "try more of these" or "eat ..." is a familiar, straight-forward version of "increase your intake of ..." or "consume ...".

● **Use legible type:** Words in text or headings are often written in all capital letters to add emphasis, but may actually make these words more difficult to read. Using upper and lower case letters and shorter line lengths, like that of newspapers, will improve readability.

● **Use relevant illustrations:** Use believable, relevant illustrations to highlight the text. Drawings of dancing bones or walking blood drops may be confusing, and may seem to trivialize or mock a person's need for information. Illustrations depicting fruit orchards and dairy farms to encourage eating fruit and dairy products will be tossed aside by urban teens. Instead, show a parked truck selling produce and the dairy aisle of a convenience store.

● **Pretest with your audience:** It is especially important to pretest new material you are developing or existing materials you plan to use. Pretest both written materials and illustrations. Pretesting will help you to assess how well the information is understood and whether the materials address the needs and concerns of your audience. You can then revise material under development or adapt the existing material.

How does *Healthy Foods, Healthy Baby* get its message across?

Healthy Foods, Healthy Baby is written between a fourth and fifth grade reading level, yet the booklet does not talk down to its readers. By using realistic characters, content, and settings, direct language, and graphics to support and ease reading, the booklet conveys clear messages. Readability is more than using one- or two-syllable words.

Realistic characters make content become alive

Most people find written material easiest to understand when they can personally relate to the content. Kim and Maria are appealing characters who have joys, concerns and interests similar to those of the reader. Focus group discussions with 60 pregnant teens were used to identify the eating habits, values and self image of young women, and to determine the vocabulary, images and visual style to which they respond best. Each of our eight focus groups was comprised of six to ten pregnant teens.

The following are examples of focus group discussion findings which provided content and context information

to help shape and refine the booklet. The teens and young women who read our booklet:

- often have poor eating habits and lack information about the principles of good eating during pregnancy;
- eat in fast food restaurants or from food carts on the street or eat meals prepared by their mothers;
- are concerned about their appearance, and worry that they will gain unwanted weight during their pregnancies;
- feel special being pregnant since others treat them as special;
- look forward to having their babies as something of their own, and are motivated by a desire to take them home from the hospital at birth;
- respond to attractive looking characters and a romantic presentation of babies and motherhood.

Conversations, behavior and settings used throughout the booklet are based upon these and other findings. Kim and Maria, the main characters of *Healthy Foods, Healthy Baby*, meet in the waiting room of a prenatal clinic. They share a desire to have a healthy baby. "I try to eat right because I want a healthy baby. I don't want to leave my baby in the hospital after I go home," Maria says.

The booklet follows Kim and Maria to a fast food restaurant, a supermarket, and the waiting room as they share the joys and discomforts of their pregnancy. Through their discussion, they convey useful information to our readers.

Some of the dialogues in the booklet are quotes from teens in our focus group discussions. For example, in the section promoting milk and foods made from milk, Kim says "Do I have to drink milk? It tastes nasty and makes me sick"—a direct quote from one teen and sentiments of many. Maria then suggests to "drink it really cold to make it taste better." Following this conversation are specific suggestions of ways to include foods that contain dairy products and alternatives, when milk causes intestinal problems.

The booklet devote several pages to choosing healthier "fast food" since many teens enjoy frequent visits to fast food restaurants, and since a food truck is located outside every prenatal clinic. This section of the booklet is the only section in which a young man appears, as the teens in our focus groups often squabble over food choices with their boyfriends at fast food restaurants (page 16 and 17 of booklet).

The booklet also refers to the wisdom and opinions of people teens told us they respected and sought help from the most: moms, grandmothers, and godmothers. These "supports" are purposefully included in sections pertaining to weight gain and infant feeding, as teens spoke of conflicting information from their family supports and health providers in these areas.

Practical food tips, a menu and food illustrations are used to suggest meals and snacks without emphasizing nutrients, portion sizes, or lengthy exchange lists. Sentences use direct, everyday language, such as "try more ..." instead of the more clinical (and ambiguous) "increase your intake of ...". Food tips are written in an active

voice. While the booklet tries to address health care workers' commitment to conveying a "discover foods attitude," most of the foods are those which teens in focus group discussions and in pretesting said they would eat. Tofu and cauliflower were taken off the lists of tips, as teens said these foods would be a turnoff to the entire booklet.

Uses graphics to ease reading

Page layout, design, color and illustrations all influence the readability of *Healthy Foods, Healthy Baby*. Upper and lower case letters are used throughout, both in the text and in most headings. Color, bold print and bullets are used instead of all capitals to add emphasis, guide reading and prepare the reader for what is coming next (page 3 of booklet).

To avoid information overload, most lists contain no more than five items. Similar items are grouped within lists to improve comprehension. Bullets are used to designate "tips." In the fast food section, foods to "try more of" and "try less of" are listed separately. Here, headings are in color to highlight the meaning of these lists and a shaded X is added for a clearer message of "try less of these." Before we added the shading, patients with whom we pretested this section could not distinguish between the two columns. They did not see the words "more" and "less". We made an exception here and used all capital letters for the words "MORE" and "LESS" in order to draw more attention to these important headings (page 16 and 17 of booklet).

The booklet's illustrations are attractive and realistic. They correspond to the adjacent text and often help to extend the message on the page. Much attention was given to developing the illustrations of Kim and Maria. Initial sketches were based upon observations of our patients. These sketches were shown to young women in prenatal clinics. Hairdos, clothing and jewelry were revised according to their comments. Patients wanted Kim and Maria to look somewhat like themselves, but just a little more together: someone to aspire to be.

Promotes interaction among patients, families and staff

Healthy foods, Healthy Baby encourages collaboration between a patient, staff and the patient's family through its design and the way it can be used. The dialogue of the booklet's main characters, Kim and Maria, lends itself to continuing the dialogue between the pregnant teen and health care staff, and the pregnant teen and her family. Patients and their health care providers can circle or underline relevant information or write in new information. For example, if a patient is experiencing heartburn and she frequently eats spicy and fried foods and drinks sodas, her health care provider could review suggestions to help get rid of heartburn which are listed on page 5 of the booklet. The patient could circle ideas she is willing to try: drink water or juice instead of soda and eat foods baked or broiled instead of fried. The patient would also circle foods in the fast food section of the booklet which are less fatty and that she will try: pizza with mushrooms instead of pizza with pepperoni or sausage; grilled chicken instead of fried chicken.

Patients are encouraged to bring their booklet to each prenatal visit as well as to share the booklet with a supportive person at home. It is critical that a patient share the information with her family member who is responsible for shopping and cooking as we found that this is generally not the patient. Additionally, most of the nutrition advice is useful for all family members.

The section on weight gain lends itself particularly well to patient involvement. A patient can record her own weight gain and gestation in the booklet at each prenatal appointment. A patient learns that all her weight gain does not go to the baby, as she looks at a picture outlining where her weight gain will be distributed.

Yellow boxes on the bottom of many pages of the booklet can be used to check topics that have been discussed. A check mark is also a reminder to staff to ask about progress in that area and to support behavior change.

Employs a team approach

Nutritionists, nurses, social workers, nurse midwives, and physicians all can use *Healthy Foods, Healthy Baby* as a focus for nutrition education. For example, a nurse may introduce the booklet during a prenatal class. A nurse weighs each patient and helps her record her weight gain and the date in the booklet. The physician or nurse midwife records the "weeks gestation." The nutritionist discusses the amount of weight gain and plots the amount on the graph, discusses progress in weight gain, evaluates her diet and discusses ideas for meals and snacks. The social worker may ask her patient if she has trouble obtaining enough food and if she has thought about breastfeeding. Patients appreciate the consistency, collaboration and reinforcement resulting from the team approach, which may enhance the compliance to the advice.

Provides multidisciplinary training

In Philadelphia, agencies serving low income pregnant women and teenagers receive a regular supply of *Healthy Foods, Healthy Baby* at no cost, provided they attend training sponsored by the Philadelphia Department of Public Health. The full day, free training program covers nutrition content, literacy principals, teaching strategies, and using the pamphlet in individual counseling and group education. The training helps to ensure the pamphlet's effective use and promotes team building. Each participant receives a training manual.

New companion materials

Following the birth of *Healthy Foods, Healthy Baby*, the Philadelphia Department of Public Health expanded its package of prenatal nutrition education materials to include a Spanish version of the booklet; two posters, one promoting use of the guidebook to be hung in the waiting room, and the other to promote optimal weight gain to be hung by the scale; a brochure about iron; and a food questionnaire and shopping list. A 12-minute video for use in prenatal classes, waiting rooms and with home visiting programs will be released in July, 1992. All are produced using the same comprehensive material development process.



Trata de pedir MÁS de...	y trata de pedir MENOS de...
Hamburguesas con tomate y lechuga, tamaño regular	Hamburguesas con salsa, tamaño doble o triple
Pollo o pescado al horno	Pollo o pescado frito o "extra crispy"
Pizza con pimientos u hongos	Pizza con peperoni, jamón, o salchichas
Ensalada, papas al horno, o ensalade de repollo ("cole slaw")	Papas fritas
Agua, jugo, o leche	Café, té, chocolate, o soda

Spanish version

The Spanish translation of the booklet was undertaken to meet a need of Philadelphia's Spanish-speaking pregnant young women and their families, most of whom are from Puerto Rico. Although many of the patients preferred receiving an English version, their mothers and grandmothers wanted the Spanish version. This version is translated into Spanish spoken in Puerto Rico and adapted to meet cultural food habits. The adaption included incorporating Puerto Rican foods in the food tips and menus. Root vegetables, plantains and tropical fruits that are available locally were substituted for foods which would be unacceptable. The supper menu was revised to include pasteles and arroz con gandules and flan as dessert. The booklet already incorporated family members, a very important element of the Puerto Rican culture. Also, the illustrations of Kim and Maria, the booklet's main characters, were readily accepted by the Puerto Rican patients.

The translation process presented several challenges. In Spanish, some concepts require more words and space than in English. To maintain important "white space,"

rewording, juggling and omitting some of the text was necessary. We found that in translating, people innocently added their own perspective and ideas, thus changing the content and sometimes causing inaccuracies. We highly recommend that translations are "back-translated" into English to assure accurate content. A review and critique by several Spanish-speaking people from Puerto Rico assisted in the translation's success.

Teaching strategies for *Healthy Foods, Healthy Baby* and other material

The best way really to reach a patient is to involve her directly. Here are some ways to do this:

1. Help her to circle, highlight, or underline ideas that are relevant and realistic;
2. Encourage her to write in any additional information or ideas that are helpful, or serve as her recorder.
3. Explain any difficult or unfamiliar terms. Consider developing a glossary of terms that frequently require an explanation.
4. Use the illustrations to clarify the text and your discussion; circle relevant pictures.
5. Use any other appropriate teaching materials to complement the content when needed;
6. Help her to identify simple, realistic changes she can make;
7. Reinforce existing positive food habits;
8. Ask your patient to summarize what food ideas she plans to try as a result of this visit.

When selecting and using other materials, use your audience as a resource. Show patients an array of available materials. Have them select those that are most appealing to them in terms of content, color, and length. Ask them to talk about what appeals or does not appeal to them and why. Providers and patients can work together to select, adapt or create useful health education materials that address the needs and concerns of patients.

The development of Healthy Foods, Healthy Baby was supported by the Maternal and Child Health Bureau, U.S. Department of Health and Human Services, through a Special Project of Regional and National Significance (SPRANS) grant MCJ 423-881.

Up to 25 copies of Healthy Foods, Healthy Baby are available at no cost from the National Maternal and Child Health Clearinghouse, 2000 15th Street North, Suite 701, Arlington, VA 22201, telephone (703) 821-8955, ext.254 (use order #C076) WIC programs may also contact Food and Nutrition Service, USDA, Nutrition and Technical Services Division, 3101 Park Center Drive, Room 609, Alexandria, Virginia 22302. Additional copies of the booklet and companion pieces are available for purchase from the Philadelphia Department of Public Health, 500 South Broad Street, Philadelphia, PA 19146; telephone (215) 875-5927.

A Feeding Problem

by
Sally Provence, M.D.

This case report, illustrating the use of mental health consultation by a pediatric nurse practitioner, is reprinted from the first issue of Zero to Three, September, 1980.

Mrs. A., the intelligent, articulate mother of Kevin, age 3 years, and Carla, age 12 months, came to the pediatric outpatient clinic requesting help for Carla's feeding problem and poor weight gain. Mrs. A. was clearly very worried about her child. The pediatric nurse practitioner who saw Carla and her mother in the clinic and a few days later at a home visit developed the following information.

Mrs. A. had enjoyed her work as a dental technician prior to Kevin's birth but expressed pleasure and satisfaction at being able to stay home to care for her children. Kevin, a delightful 3 year old, had grown and developed well and was enjoying his attendance at nursery school. Mr. A. was successful as an insurance salesman, was very proud of his children and minimally involved in their care. Carla, weighing 7 lbs. 3 oz. when born at term of an uncomplicated pregnancy and labor, had done well as a newborn. Mrs. A. started breast feeding but the infant did not seem satisfied; on bottle feedings things went reasonably well for a time, though Carla was not a big eater.

Mrs. A. first became concerned about the baby's weight gain when Carla was 5 months old and the pediatrician called it to her attention. While there was no weight loss or dramatic change between the 5th and 10th months Carla's growth curve fell from the 10th percentile to below the 3rd percentile. Carla was very selective about solids, and her intake did not meet her nutritional needs. Extensive studies arranged by her pediatrician, when Carla was 10-11 months old, revealed no physical reason for the problems. Mrs. A. understood, but was not able to follow, the advice she received after these studies—that she should relax, let the infant take what she would, and wait for Carla to "come around."

Mrs. A. spoke movingly to the nurse of her great worry that Carla would sicken and die. She volunteered that perhaps she was fearful because her mother had died of cancer 2 years earlier and she could not bear another loss. She had some awareness that she had become increasingly anxious and discouraged and that Carla ate less well when Mrs. A. was unrelaxed during feeding. When asked whether anyone else had fed Carla she responded that she would not permit it, that she was the mother and it was her place to feed her child.

At the home visit the nurse noted something that had not emerged before. She observed a feeding in which Mrs. A., with the assistance of a neighbor, was force feeding Carla. When the infant refused a third bite of fruit from the spoon, Mrs. A. nodded to her friend, who held Carla's nose while Mrs. A. spooned in the food and then held Carla's mouth closed until she swallowed. When

asked about this, Mrs. A. said she was trying it because she didn't know what else to do. The infant looked bewildered and distressed and after a few moments regurgitated the food, to Mrs. A.'s dismay and tears. But at the end of this visit she seemed to feel some confidence in the nurse, felt that she was sympathetic, and expressed the hope that the nurse could help.

Carla was described as a bright-eyed infant of 12 months who, though small, did not appear ill or malnourished. She was relatively inactive motorically, but could creep on all fours. She clearly discriminated between familiar and unfamiliar persons and preferred her mother. She responded with smiles and motor activity when Kevin talked with her and clowned for her benefit. When not being fed, she was responsive and could be engaged in social play, though she was less robust in her affective expression than many infants of her age. As Carla was placed in her high chair for feeding, she became solemn, passive and at times looked apprehensive.

"Whatever the underlying basis of Mrs. A's problem in feeding Carla successfully, she was in other respects taking good care of her and needed immediate, practical assistance with the feeding situation."

At this juncture, the nurse, having talked with the mother about her wish to discuss Carla with professional colleagues, presented the foregoing material to the mental health consultant at the clinic. While at first the nurse expected to refer Mrs. A. immediately to someone else for assistance with what appeared to be an increasingly severe problem in the mother's ability to nurture her infant well, the consultant pointed out that this would be an error, since Mrs. A. obviously liked the nurse and seemed ready to receive assistance from her around the feeding. It was clear that, whatever the basis of Mrs. A.'s problem in feeding Carla successfully, she was in other respects taking good care of her and needed immediate, practical assistance with the feeding situation.

It was thought that the basis of Mrs. A.'s great anxiety around the feeding might be the death of her own mother just prior to the pregnancy with Carla, and that Mrs. A.'s possible equation of Carla and her mother was a force in the current picture. Nonetheless the consultant pointed out that it would be no service to Mrs. A. and Carla to focus attention on this issue at this time, even though it might have great relevance for the mother-child relationship. A plan was made for the nurse to continue to visit Mrs. A. and Carla and to try to help Mrs. A. make the feeding time less tense. This involved giving her practical suggestions about feeding techniques, including permitting Carla to do some self feeding, and reassuring Mrs. A. that Carla was basically a healthy baby and that she, the nurse, would stick with Mrs. A. as long as she was needed.

Mrs. A. responded with gratitude and some ability to identify with the nurse's optimism about the outcome. She also allowed the nurse to feed Carla directly at times,

help she had not been able to accept from her relatives or friends. Though there were ups and downs, the feeding situation steadily improved during the next weeks. Carla gained weight, and each improvement further encouraged and relieved Mrs. A. What had been a worrisome and potentially damaging problem had been alleviated.

Comment

In this case the pediatric nurse practitioner using the skills of her profession addressed a problem important to both the physical and mental health of the infant. It was not necessary in this instance to understand and deal

with the sources of Mrs. A.'s obvious anxiety about the survival of her child in order to help her. A crisis in the mother-child relationship has been lessened. One cannot know, except, on further contact, whether Mrs. A.'s apparent association of Carla with her own mother is indeed relevant and will be an influence, for good or ill, in the future. Mrs. A.'s ability to trust the nurse's skill and the nurse's commitment not to abandon her and Carla appear to have been very important factors in the improvement. The case also illustrates how direct observation of mother and child facilitates understanding.

Pediatric Nutrition Practice Group: Promoting Child Health Through Optimal Nutritional Care

by Susan Krug-Wispe, MS, RD, Past PNPG Chair

The Pediatric Nutrition Practice Group (PNPG) is one of 23 dietetic practice groups (DPGs) under the Council on Practice of The American Dietetic Association (ADA). PNPG membership is open to all members of ADA who practice or have an interest in pediatric nutrition. Its purpose is to promote optimal health and nutritional status of the pediatric population through direction and leadership for quality dietetic practice, education, and research.

PNPG actively works to advance the provision of quality nutrition services to children. The PNPG Legislative Committee monitors national legislative activities involving child nutrition programs and serves as a resource to the national ADA Division of Government. PNPG promotes the delivery of quality nutritional care to children in various health care settings through its development, field testing and publication of criteria sets for the manual *Quality Assurance Criteria for Pediatric Nutrition Conditions: A Model*.^{**} PNPG also initiated and worked with ADA and the various professional organizations involved in the development of the newly released publication *Preparation of Formula for Infants: Guidelines for Health Care Facilities*.^{**} Networking to share ideas and resources often en-

hances health care delivery. Networking among pediatric nutrition professionals within the seven ADA geographic areas has been encouraged through the PNPG's quarterly *Area Updates*. These bulletins enable nutrition professionals to share information on upcoming local or regional educational or employment opportunities, newly developed client or professional educational materials, and other pediatric nutrition-related activities. Networking with ADA organizational units serving pediatric populations such as the DPGs Public Health Nutrition and Dietetics in Developmental and Psychiatric Disorders has been effective for coordinating educational opportunities and materials development. During the past year PNPG has had the opportunity to expand its networking to include other professional organizations serving children through ADA's Alliance Program. These relationships will enable PNPG to become more involved in multidisciplinary activities.

Participation in the provision of continuing professional education is a primary function of PNPG. Information on current issues and advances in nutritional risk identification and intervention are regularly included in the *Building Blocks*. PNPG's quarterly publication. PNPG annually plans a pediatric educational session for the ADA Annual Meeting and has initiated an education-

al grants program to support pediatric nutrition presentations at regional meetings. PNPG representatives routinely serve on program planning committees for the National March of Dimes regional meetings on maternal and child nutrition.

Nutrition research is PNPG's third area of focus as it provides the groundwork for advances in nutritional care. PNPG supports pediatric nutrition research through a \$1000 Grant, the Glenda Bible Memorial Scholarship, and a Published Research Award, all awarded annually.

PNPG is now entering its fifteenth year and has grown to more than 1900 members. Its achievements have been facilitated by the willingness of its members to contribute time and expertise to improving pediatric nutritional care. PNPG anticipates a bright and productive future impacting infant and child health into the next century.

^{**}Publications are available from the ADA Sales/Order Department, 216 West Jackson Boulevard, Suite 800, Chicago, IL 60606-6995, tel.: (312) 899-0040.

Should the Field of Early Child and Family Intervention Address Failure To Thrive?

by

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Infants and toddlers with failure to thrive (FTT) have concerned professionals for years. Research has shown that undernutrition impairs brain function; children with FTT also face environmental and social risks to their development. As early intervention programs expand, it seems logical to ask whether the needs of children with FTT and their families should qualify them for early intervention.

FTT is generally defined in terms of growth. When children are undernourished, they fail to gain weight as well as expected. After a few months their growth in length also falters. On the growth charts of the National Center for Health Statistics, they drop below the third or fifth percentiles of weight or height. Most children are diagnosed with FTT when their weight or height percentiles are low; others are diagnosed when their growth crosses percentile lines downward even though it may not have fallen below the fifth percentile.

Undernutrition in the United States is frequently thought to be associated with psychosocial problems and is called failure to thrive; undernutrition in the Third World is usually attributed to poverty and is called protein-energy malnutrition (Rathbun & Peterson, 1987). The two conditions are really the same: FTT in the United States is often associated with poverty, and families in the Third World whose infants develop malnutrition are more likely than others to have social problems. This article will draw on both domestic and Third World literature.

In working with families, many practitioners prefer not to label children as having FTT, because it implies failure on the part of parents. Other terms are preferable: "growth problem," "underweight," "not gaining weight well," and "undernutrition." In this paper I will generally use the term "failure to thrive" because 29 states list it as an established condition or a biologic risk factor for early intervention (Carolina Policy Studies Program, 1992).

Historically FTT has been classified as either organic, i.e. due to illness and other biologic factors, or nonorganic, implying psychosocial causes. Presently many authors recognize that many cases are of mixed etiology: sick infants affect their parents, and all infants with FTT, including neglected ones, are malnourished (Frank & Zeisel, 1988).

Failure to thrive is all too common. In a nationwide sample of low-income children, two to five percent were underweight for their height (Centers for Disease Control, 1983). In Massachusetts, 1.4 percent of children in Head Start and two to three percent of children in health centers and emergency rooms were underweight (Dietz, 1990). If one looks at children whose height has been stunted, the figures are larger: six to 16 percent of children in a large national sample of children 0-4 years old from low-income families (Centers for Disease Control, 1983).

Failure to thrive is associated with poverty. Children from low-income families are lighter and shorter than others (Jones, Nesheim, & Habicht, 1985); minority children are smaller than white children (Centers for Disease Control, 1987). Almost all studies of FTT have been done in low-income populations; little is known about FTT in affluent ones. Therefore, the conclusions of this article will apply mainly to children from low-income families in the U.S.

Failure to thrive is also associated with biologic factors. Low birth weight predisposes children to growing up small; so do many chronic illnesses. Some of these conditions, such as fetal alcohol syndrome and chromosomal disorders, qualify children for early intervention in many states. This article will emphasize children who are nutritionally and emotionally deprived because of environmental factors. In many such cases, however, medical factors are still important.

Early intervention

In considering whether infants with FTT and their families should be served by early intervention programs, let us look at the eligibility criteria for Part H of the Individuals with Disabilities Education Act, previously known as Part H of P.L. 99-457 (Carolina Policy Studies Program, 1992). The criteria include:

- 1) Developmental delays
- 2) Established conditions "with a high probability of resulting in delayed development"
- 3) Biological or environmental conditions associated with risk of delays.

States must serve children in groups 1 and 2; those in group 3 are optional, and states can define the at-risk groups they will serve.

Concurrent developmental problems

If children have developmental delays when they have FTT, they are eligible for services under Part H. Do children who fail to thrive have such delays?

Two studies have included infants hospitalized for FTT in the first year of life and compared them to controls from well-baby clinics. The studies used the Bayley Scales of Infant Development, on which 100 is average and 16 is one standard deviation. In one study, 18 children with nonorganic FTT had scores on the Bayley Mental Development Index (MDI) averaging around 85, lower than controls and the same as abused children (Fitch, Cadol, Goldson, Wendell, Swartz, & Jackson, 1976). The

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second study looked at 13 children with organic FTT, 13 with nonorganic FTT and 13 controls. Those with organic FTT had Bayley MDI's averaging 68; those with nonorganic, 78; both were lower than controls. On followup at 20 months and three years the delays persisted (Singer & Fagan, 1984). In a third study, without controls, 17 children had Bayley MDI's averaging 81 on admission, but they improved to 95 three months later (Field, 1984). On balance it appears that infants from low-income families hospitalized for FTT in the first year of life are likely to show delays in cognitive development.

Many children with poor growth are not hospitalized or even medically treated for it. A study from London is relevant to these children. Subjects were selected from a population-based pediatric service serving all children in an inner-city health district in London. Twenty-three cases were identified on the basis of low weight and height at four years of age; controls were matched on sex and gestational age and were recruited from the same clinics. The measure of mental development, the General Cognitive Index (GCI) of the McCarthy Scales of Children's Abilities, has a mean of 100 and a standard deviation of 16. Mean scores were 77 for cases and 100 for controls. Of 23 cases, 8 had GCI scores below 70; of 23 controls, none did (Dowdney, Skuse, Heptinstall, Puckering, & Zur-Szpiro, 1987).

Attachment disorders should also be considered as concurrent developmental problems since 24 states list them as established conditions qualifying for services. Insecure attachment, as rated in a research procedure, the Ainsworth Strange Situation, was present more frequently in cases of FTT than in controls in three recent studies. 1) Among children from families of a wide range of income, children with FTT, organic or nonorganic, had higher rates of insecure attachment than controls: 64 percent vs. 36 percent (Ward, Kessler, & Altman, 1992). 2) Among children with FTT, abused and neglected by their parents and referred to protective services, 92 percent of children with FTT were insecurely attached, compared to 33 percent of controls (Crittenden, 1987). 3) In Santiago, Chile, chronically undernourished children had a higher prevalence of insecure attachment (93 percent) than did controls (50 percent).

Thus children with FTT appear quite likely to experience insecure attachment. This finding justifies evaluation and services to many cases.

Studies have shown less organized meals and more difficulties in feeding among families with children who are failing to thrive than controls (Pollitt & Eichler, 1976). Mothers have been less sensitive, infants more negative, and vocal interactions fewer in FTT cases than comparisons (Berkowitz & Senter, 1987; Drotar, Eckerle, Satola, Pallotta, & Wyatt, 1990; Polan, Leon, Kaplan, Kessler, Stern, & Ward, 1991). A common pattern of toddlers refusing food and parents forcing it has been called a disorder of separation and individuation (Chatoor & Egan, 1983).

The studies of concurrent problems of children with FTT imply a need for services. The high frequency of cognitive delays and attachment disorders at the time of

FTT give ample reason for evaluating children who are failing to thrive and providing developmental services to many of them.

Risk of subsequent developmental problems

Failure to thrive generally occurs in the first two years of life, so identification of developmental risk is made more difficult by the fluidity of early development and the difficulty of prediction at a young age. Yet it is important to look at risks affecting later development because children with FTT might qualify for services because of these risks.

Children with FTT can qualify for services if FTT is considered an established condition with high risk of subsequent developmental problems. Examples of such established conditions are Down syndrome and phenylketonuria. Children might also qualify if FTT were considered a biologic risk factor like low birth weight. Currently 13 states consider FTT an established condition and 16 consider it a biologic risk factor (Carolina Policy Studies Program, 1992). Unfortunately, few studies have looked at the long-term results of FTT in terms of the proportion of children needing special services. Thus it is difficult to establish from the literature the exact probability of subsequent developmental problems. There is mounting evidence, however, that FTT carries with it a number of risk factors.

Undernutrition as a risk

Undernutrition itself is clearly a risk factor. Two types of research studies have shown this: long-term outcome studies of children with FTT during infancy and intervention studies intended to improve current development.

Most studies of long-term outcome have been conducted in Third World countries. Most have emphasized IQ as an outcome measure, but several have also considered behavior. In children in Barbados with moderate to severe malnutrition during the first year of life, follow-up to the age of 15 years showed lower IQ's, lower ratings of attention, and lower school achievement, even after controlling for family environment (Galler & Ramsey, 1989; Galler, Ramsey, Solimano, & Lowell, 1983). Jamaican boys hospitalized in the first two years of life for malnutrition who were studied at 5-10 years of age functioned less well in school in attention, memory, distractibility, spontaneity, and cooperation, compared to their brothers and to male classmates (Richardson, Birch, Grabie, & Yoder, 1972).

One study in a developed country, Australia, has followed children hospitalized in infancy with failure to thrive. Of 14 children followed up 13 years later, eight were reading three years or more below their chronologic age, against one in 14 comparison children (Oates, Peacock, & Forrest, 1985).

Intervention studies in the Third World have shown that improving nutrition benefits child development. In Jamaica, nutritional supplementation and stimulation improved cognitive development. Each form of intervention was beneficial, and their effects were additive (Grantham-McGregor, Powell, Walker, & Himes, 1991).

Similar effects of improved nutrition have been seen in Colombia and Guatemala (Barrett, Radke-Yarrow, & Klein, 1982; Waber, Christiansen, Ortiz, Clement, Christiansen, Mora, & Reed, 1981).

Environmental risks

A nurturant and stimulating environment provides substantial protection against the effects of early malnutrition, as it does against low birth weight. Unfortunately, many infants with FTT do not have nurturant and stimulating home environments that might buffer the effects of nutritional deprivation. FTT children have less stimulating home environments than controls, as shown on the Home Observation for Measurement of the Environment scale (Casey, Bradley, & Wortham, 1984).

Parents and families of children with FTT are more likely than controls to have psychosocial problems. Recent studies have shown that mothers of children with FTT report poor nurturance during childhood (Altemeier, O'Connor, Sherrod, & Vietze, 1985), are insecurely attached themselves (Benoit, Zeanah, & Barton, 1989), and are more likely than controls to have affective and personality disorders (Polan, Kaplan, Kessler, Schindedecker, Newmark, & Stern, 1991). Fathers have seldom been studied, but case examples have shown instances of fathers participating in marital conflict (Altemeier, O'Connor, Sherrod, & Vietze, 1985) and maladaptive parenting (Drotar & Sturm, 1987). Studies of the family system have shown social isolation (Bithoney & Newberger, 1987) and problematic family relationships (Drotar & Eckerle, 1989; Crittenden, 1987).

Biological risks

Biological risks are also associated with FTT. One associated risk is low birth weight: about 20 percent of cases of children from low-income families whose length is low for age have had birth weights under 2500 grams, compared to about 7 percent for the general population (Gayle, Dibley, Marks, & Trowbridge, 1987). Other risk factors that children with FTT may have are infection and toxic exposures. Children with FTT frequently have ear infections, diarrhea and other minor illnesses. In areas like urban ghettos where housing is old, lead poisoning can be a factor. These medical factors can impair growth; some of them can also impair development. The same is true of many chronic illnesses.

Multiple risks

It is easy to see that children with FTT will often experience multiple risk factors. These may well add up, so that a child with more risk factors is more likely to suffer in his development. That possibility has not been studied with FTT but was confirmed among low-income children in whom ten components of environmental risk were measured (Sameroff, Seifer, Barocas, Zax, & Greenspan, 1987). Use of multiple factors has been recommended as a way of making eligibility criteria more effective (Carolina Policy Studies Program, 1992).

The combination of nutritional, environmental and biologic risks provides good reason for early intervention

programs to address the needs of children with FTT and their families. Such children and their families should be evaluated and many should qualify for services.

Intervention for failure to thrive: Assessment

Research in recent years has shown ways in which intervention programs can be tailored to individual needs. Many authors have dropped the simple distinction between organic and nonorganic etiologies, recognizing that many cases are mixed (Frank & Zeisel, 1988). Moreover, groups of children with FTT and families are seen as heterogeneous and requiring individual evaluation. FTT may represent anything from a parental misunderstanding about the preparation of formula to child neglect rooted in family pathology.

To address the multiple needs that a child with FTT and his family may present, the evaluation and treatment should be done by an interdisciplinary team (Bithoney, McJunkin, Michalek, Snyder, Egan, & Epstein, 1991; Frank & Zeisel, 1988). A nutritionist should evaluate the child's intake and feeding behavior (Peterson, Washington, & Rathbun, 1984). A physician should look for medical etiologies, such as low birth weight, fetal alcohol syndrome, and lead poisoning (Frank & Zeisel, 1988). The nutritionist or the physician should evaluate the severity of the child's growth deficit. Occupational, physical or speech therapy may be needed, as in cases of language delays or difficulty in swallowing.

A mental health professional should evaluate the child's cognitive development and behavior. In doing so, standard measures may help to describe the child's problem in quantitative terms. Examples of such measures are the Bayley Scales of Infant Development and the Achenbach Child Behavior Checklist for two- and three-year-olds (Achenbach, Edelbrock, & Howell, 1987). Although it is not feasible in service programs to use the Ainsworth Strange Situation to rate attachment, one can use psychiatric diagnoses of the Diagnostic and Statistical Manual of the American Psychiatric Association (American Psychiatric Association, 1987). An example of a diagnosis in the current edition that may apply to infants with FTT is Reactive Attachment Disorder; another possibility is Major Depressive Disorder (Powell & Bettes, 1992). New diagnoses relevant to infants and young children may appear in the next edition of the manual.

Home visits can greatly enrich the assessment process (Drotar & Crawford, 1987). It is very helpful to observe interactions during feeding. Other areas to address include the availability of food, daily routines for sleep and feeding, the parents' approach to discipline, and informal sources of support and advice. Diagrams of the family tree may help parents start talking about family relationships (Drotar, Wilson, & Sturm, 1989).

Services to children and families

Service programs for FTT described in the literature have generally been based in pediatric clinics of university hospitals. They have included interdisciplinary teams of physicians, nurses, nutritionists, and social workers. Physicians have treated infections and other illnesses; nutritionists have provided guidance on food choices and

feeding; social workers have addressed financial and psychosocial problems of families. In these programs most children, though not all, have gained weight (Bithoney, McJunkin, Michalek, Snyder, Egan, & Epstein, 1991; Casey, Wortham, & Nelson, 1984). Such services are plainly important in the treatment of FTT and are the most quickly needed ones when a child first presents (Frank & Drotar, 1992). Some children must be hospitalized.

Services for associated psychological problems are less well established. Needs will vary: some families will benefit from guidance on children's behavior; others will need family therapy; children may need referral to Head Start, preschool or developmental programs. Infant-parent psychotherapy shows promise for some troubled families and in one study increased the frequency of secure attachment (Fraiberg, Adelson, & Shapiro, 1980; Lieberman, 1991; Lieberman, Weston, & Pawl, 1991). Some cases will require reporting to protective services because of poor compliance after voluntary efforts, parental substance abuse, or suspected physical injury (Frank & Drotar, 1992; Hathaway, 1989).

It is important to develop strong helping relationships with families (Brammer, 1988). All members of the team can benefit families by making home visits. Community health nurses can play an important role in doing home assessments and reaching families if they are inconsistent about coming to a clinic (Anderson, 1980; Klein, 1990). Paraprofessional home visitors can provide emotional support and help in using community agencies (Dawson, van Doorninck, & Robinson, 1989). The latter may be important because surveys of severe pediatric undernutrition in the U.S. have shown that families underuse available community resources (Florida Department of Health and Rehabilitative Services, 1990).

A promising source of funding for these services is Medicaid. If a child is found to need services in a well-child exam (called EPSDT, Early and Periodic Screening, Diagnosis and Treatment), and if the services are medically necessary, the state is required to pay for them, even if they are not included in the state Medicaid plan (Children's Defense Fund, 1990). Most states are at an early stage of meeting this requirement.

Interventions in policy

It would be remiss of us not to address the social policies of this country that make FTT more common: poverty and unavailability of adequate nutrition. Nearly one-fourth of families with children live below the poverty line. Poverty underlies many of the developmental problems of our children (Kaplan-Sanoff, Parker, & Zuckerman, 1991; Parker, Greer, & Zuckerman, 1988).

Clinical interventions will have limited effect while the life situations of millions of families are impoverished. Clinicians can improve public policy by speaking up: by reading newsletters (American Academy of Pediatrics and Children's Defense Fund—see references) and by writing letters to candidates and elected officials.

Policies that could help include increasing the minimum wage, providing tax credits for families with children, and

enforcing requirements for absent fathers to provide child support (Bane & Ellwood, 1989; Children's Defense Fund, 1991; National Commission on Children, 1991). Measures like these do not involve the negative values associated in many people's minds with welfare (Ellwood, 1988).

Also important are nutrition programs. The Women, Infants and Children Program (WIC) has improved diet, reduced the prevalence of anemia, and increased birth weight and infant growth (Edozi, Switzer, & Bryan, 1979; Rush, Leighton, Sloan, Alvir, Horvitz, & Seaver, 1988). However, it currently covers only 60 percent of the income-eligible children. Its budget should be expanded to meet the remaining needs.

Winston Churchill said it best: "There is no finer investment for any community than putting milk into babies" (Edelman, 1987).

References

- Achenbach, T.M., Edelbrock, C., & Howell, C.T. (1987). Empirically based assessment of the behavioral-emotional problems of 2- and 3-year-old children. *Journal of Abnormal Child Psychology*, 15, 629-650.
- Altmeier, W.A., III, O'Connor, S.M., Sherrod, K.B., & Vietze, P.M. (1985). Prospective study of antecedents for nonorganic failure to thrive. *Journal of Pediatrics*, 106, 360-365.
- American Academy of Pediatrics. AAP Washington Report, 1331 Pennsylvania Avenue, NW, Suite 721 North, Washington, DC 20004-1703. Phone 800-336-5475.
- American Psychiatric Association (1987). *Diagnostic and Statistical Manual of Mental Disorders (DSM-III-R)*. Washington, DC: Author.
- Anderson, C. (1980). A community health nursing role in child abuse/neglect intervention. *Child Abuse and Neglect*, 4, 33-38.
- Bane, M.J. & Ellwood, D.T. (1989). One fifth of the nation's children: Why are they poor? *Science*, 245, 1052.
- Barrett, D.E., Radke-Yarrow, M., & Klein, R.E. (1982). Chronic malnutrition and child behavior: Effects of early caloric supplementation on social and emotional functioning at school age. *Developmental Psychology*, 18, 541-556.
- Benoit, D., Zeana, C.H., & Barton, M.L. (1989). Maternal attachment disturbances in failure to thrive. *Infant Mental Health Journal*, 10, 185-202.
- Berkowitz, C.D. & Senter, S.A. (1987). Characteristics of mother-infant interactions in nonorganic failure to thrive. *Journal of Family Practice*, 25, 377-381.
- Bithoney, W.G., McJunkin, J., Michalek, J., Snyder, J., Egan, H., & Epstein, D. (1991). *Journal of Developmental and Behavioral Pediatrics*, 12, 254-258.
- Bithoney, W.G. & Newberger, E.H. (1987). Child and family attributes of failure-to-thrive. *Journal of Developmental and Behavioral Pediatrics*, 8, 32-36.
- Brammer, L.M. (1988). *The Helping Relationship*. Englewood Cliffs, NJ: Simon and Schuster.
- Carolina Policy Studies Program. (1992). State eligibility policies for part H of IDEA: Conditions relating to failure to thrive. Unpublished raw data.
- Casey, P.H., Bradley, R., & Wortham, B. (1984). Social and nonsocial home environments of infants with nonorganic failure-to-thrive. *Pediatrics*, 73, 348-353.
- Centers for Disease Control (1983). Prevalence of growth stunting and obesity: Pediatric nutrition surveillance summary. *CDC Surveillance Summaries*, 32 (No. 455), 2355-2655.
- Centers for Disease Control (1987). Nutritional status of minority children—United States, 1986. *Morbidity and Mortality Weekly Report*, 36, 366-369.
- Chatoor, I. & Egan, J. (1983). Nonorganic failure to thrive and dwarfism due to food refusal: A separation disorder. *Journal of the American Academy of Child Psychiatry*, 22, 294-301.
- Children's Defense Fund (1990). Improving the health of Medicaid-eligible children. *CDF Reports*, April.
- Children's Defense Fund. CDF Reports, 122 C Street, N.W., Washington, DC 20001. Phone 202-628-8787.

- Children's Defense Fund (1991). *The State of America's Children, 1991*. Washington, DC: Author.
- Crittenden, P.M. (1987). Non-organic failure-to-thrive: deprivation or distortion? *Infant Mental Health Journal*, 8, 51-64.
- Dawson, P., van Doorninck, W.J., & Robinson, J.L. (1989). Effects of home-based, informal social support on child health. *Journal of Developmental and Behavioral Pediatrics*, 10, 63-67.
- Dietz, W.H. (1990). Undernutrition of children in Massachusetts. *Journal of Nutrition*, 120, 948-954.
- Dowdney, L., Skuse, D., Heptinstall, E., Puckering, C., & Zur-Szpiro, S. (1987). Growth retardation and developmental delay amongst inner-city children. *Journal of Child Psychology and Psychiatry and Allied Disciplines*, 28, 529-541.
- Drotar, D. & Crawford, P. (1987). Using home observation in the clinical assessment of children. *Journal of Clinical Child Psychology*, 16, 342-349.
- Drotar, D. & Eckerle, D. (1999). The family environment in nonorganic failure to thrive: a controlled study. *Journal of Pediatric Psychology*, 14, 245-257.
- Drotar, D., Eckerle, D., Satola, J., Pallotta, J., & Wyatt, B. (1990). Maternal interactional behavior with nonorganic failure-to-thrive infants: a case-comparison study. *Child Abuse and Neglect*, 14, 41-51.
- Drotar, D. & Sturm, L. (1987). Paternal influences in non-organic failure to thrive. *Infant Mental Health Journal*, 8, 37-50.
- Drotar, D., Wilson, F., & Sturm, L. (1989). Parent intervention in the management of failure to thrive. In C.E. Schaefer & J.M. Briesmeister (Eds.), *Handbook of Parent Training: Parents as Co-Therapists for Children's Behavioral Problems*. New York, NY: John Wiley.
- Edelman, M.W. (1987). *Families in Peril: An Agenda for Social Change*. Cambridge, MA: Harvard University Press.
- Edozi, J.C., Switzer, B.R., & Bryan, R.B. (1979). Medical evaluation of the Special Supplemental Food Program for Women, Infants and Children. *American Journal of Clinical Nutrition*, 32, 677-692.
- Ellwood, D.T. (1988). *Poor Support: Poverty in the American Family*. New York: Basic Books.
- Field, M. (1984). Follow-up developmental status of infants hospitalized for nonorganic failure to thrive. *Journal of Pediatric Psychology*, 9, 241-256.
- Fitch, M.J., Cadot, R.V., Goldson, E., Wendell, T., Swartz, D., & Jackson, E. (1976). Cognitive development of abused and failure-to-thrive children. *Journal of Pediatric Psychology*, 1, 32-37.
- Florida Department of Health and Rehabilitative Services. (1990). *Surveillance of Severe Pediatric Undernutrition in Florida*. Tallahassee: Author.
- Fraiberg, S., Adelson, E., & Shapiro, V. (1980). Ghosts in the nursery: A psychoanalytic approach to the problems of impaired infant-mother relationships. In S. Fraiberg (Ed.), *Clinical Studies in Infant Mental Health*. New York: Basic Books.
- Frank, D.A. & Drotar, D. (1992). Failure to thrive. In R. Reece (Ed.), *Child Abuse*. Lea and Febiger, in press.
- Frank, D.A. & Zeisel, S.H. (1988). Failure to thrive. *Pediatric Clinics of North America*, 35, 1187-1206.
- Galler, J.R. & Ramsey, F. (1989). A follow-up study of the influence of early malnutrition on development: Behavior at home and at school. *Journal of the American Academy of Child Psychiatry*, 28, 254-261.
- Galler, J.R., Ramsey, F., Solimano, G., & Lowell, W. (1983). The influence of early malnutrition on subsequent behavioral development: I. Degree of impairment in intellectual performance. *Journal of the American Academy of Child Psychiatry*, 22, 8-15.
- Gayle, H., Dibley, M., Marks, J., & Trowbridge, F. (1987). Malnutrition in the first two years of life: The contribution of low birth weight to population estimates in the United States. *American Journal of Diseases of Children*, 141, 531-534.
- Graham-McGregor, S.M., Powell, C.A., Walker, S.P., & Himes, J.H. (1991). Nutritional supplementation, psychosocial stimulation, and mental development of stunted children: The Jamaican Study. *Lancet*, 338, 1-5.
- Hathaway, P. (1989). Failure to thrive: knowledge for social workers. *Health and Social Work*, 14, 122-126.
- Jones, D., Nesheim, M., & Habicht, J. (1985). Influences on child growth associated with poverty in the 1970's: An examination of HANES I and HANES II, cross-sectional U.S. national surveys. *American Journal of Clinical Nutrition*, 42, 714-724.
- Kaplan-Sanoff, M., Parker, S., & Zuckerman, B. (1991). Poverty and early childhood development: What do we know and what should we do? *Infants and Young Children*, 4, 68-76.
- Klein, M.J. (1990). The home health nurse clinician's role in the prevention of nonorganic failure to thrive. *Journal of Pediatric Nursing*, 5, 129-135.
- Lieberman, A.F. (1991). Infant mental health: A model for service delivery. *Journal of Clinical Child Psychology*.
- Lieberman, A.F., Weston, D.R., & Pawl, J.H. (1991). Preventive intervention and outcome with anxiously attached dyads. *Child Development*, 62, 199-209.
- National Commission on Children. (1991). *Beyond Rhetoric: A new American agenda for children and families*. Washington, DC: Author.
- Oates, R.K., Peacock, A., & Forrest, D. (1985). Long-term effects of nonorganic failure to thrive. *Pediatrics*, 75, 36-40.
- Parker, S., Greer, S., & Zuckerman, B. (1988). Double jeopardy: The impact of poverty on early child development. *Pediatric Clinics of North America*, 35, 1227-1240.
- Peterson, K.E., Washington, J., & Rathbun, J.M. (1984). Team management of failure to thrive. *Journal of the American Dietetic Association*, 84, 810-815.
- Polan, H.J., Kaplan, M.D., Kessler, D.B., Schindlacker, R., Newmark, M., Stern, D.N., & Ward, M.J. (1991). Psychopathology in mothers of children with failure to thrive. *Infant Mental Health Journal*, 12, 55-64.
- Polan, H.J., Leon, A., Kaplan, M.D., Kessler, D.B., Stern, D.N., & Ward, M.J. (1991). Disturbances of affect expression in failure-to-thrive. *Journal of the American Academy of Child and Adolescent Psychiatry*, 30, 897-903.
- Pollitt, E. & Eichler, A. (1976). Behavioral disturbances among failure-to-thrive children. *American Journal of Diseases of Children*, 130, 24-29.
- Powell, G.F., & Bettes, B.A. (1992). Infantile depression, nonorganic failure to thrive, and DSM-III-R: A different perspective. *Child Psychiatry and Human Development*, 22, 185-198.
- Rathbun, J.M. & Peterson, K.E. (1987). Nutrition in failure to thrive. In R.J. Grand, J.L. Sutphen, & W.H. Dietz, Jr. (Eds.), *Pediatric Nutrition: Theory and Practice*. Boston: Butterworth Publishers.
- Richardson, S.A., Birch, H.G., Grabie, E., & Yoder, K. (1972). The behavior of children in school who were severely malnourished in the first two years of life. *Journal of Health and Social Behavior*, 13, 276-284.
- Rush, D., Leighton, J., Sloan, N.L., Alvir, J.M., Horvitz, D.G., Seaver, W.B., Garbowski, G.C., Johnson, S.S., Kulka, R.A., Devore, J.W., Holt, M., Lynch, J.T., Virag, T.G., Woodside, M.B., & Shanklin, D.S. (1988). The national WIC evaluation: Evaluation of the special supplemental food program for women, infants, and children. VI. Study of infants and children. *American Journal of Clinical Nutrition*, 48, 484-511.
- Sameroff, A., Seifer, R., Barocas, R., Zax, M., & Greenspan, S. (1987). Intelligence quotient scores of 4-year-old children: Social-environmental risk factors. *Pediatrics*, 79, 343-350.
- Singer, L.T. & Fagan, J.F. (1984). Cognitive development in the failure-to-thrive infant: a three-year longitudinal study. *Journal of Pediatric Psychology*, 9, 363-383.
- Waber, D., Christiansen, L., Ortiz, N., Clement, J., Christiansen, N., Mora, J.O., Reed, R., & Herra, M. (1981). Nutrition supplementation, maternal education, and cognitive development of infants at risk of malnutrition. *American Journal of Clinical Nutrition*, 34, 807-813.
- Ward, M.J., Kessler, D.B., & Altman, S.C. (1992). Infant-mother attachment in children with failure to thrive. Unpublished manuscript.

Communication Strategies for Working with Parents of Infants Who Fail to Thrive

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A productive working alliance between parents and professionals is critical to the successful treatment of growth problems in infants and toddlers. Understanding parents' health beliefs—their unique interpretation of the child's growth deficiency, its causes, consequences, and treatment—can equip the practitioner to communicate with parents more effectively, thereby promoting a strong working relationship. In our own clinical work, however, we have found that pediatric and early intervention staff are often unaware of how parents understand their child's failure to thrive. Although these well-intentioned professionals work hard to involve parents, communications problems may frustrate their efforts. The result may be parental opposition (removing a child from the hospital against medical advice or "doctor shopping") or withdrawal (missing appointments or noncompliance with treatment recommendations). The parent-professional partnership that the very young child with a growth problem needs so urgently may be delayed or derailed by communication problems.

The following suggestions for optimizing staff-parent communication use parental health beliefs as a framework for considering the parent's experience of nonorganic failure to thrive (NOFT) and pediatric encounters (Sturm and Drotar, 1991). The strategies we offer were derived from our clinical experiences with families of infants and toddlers with NOFT and from research on parental health beliefs about growth problems. They speak to parental recognition of the symptoms of a growth problem, parents' explanations of etiology, their understanding of the potential seriousness of consequences of NOFT, and the treatment approaches that parents consider appropriate.

We have discovered that becoming aware of parents' health perceptions early on helps staff to identify maladaptive parental beliefs and attitudes that may be modifiable. In addition, familiarity with the range of expectable parental perceptions about growth problems can prevent staff from responding inappropriately to parents who sometimes engender intense feelings of anger, helplessness, and frustration toward the parent and protective impulses toward the child.

1. Be sensitive to the fact that a problem with weight gain in an infant or toddler poses a significant threat to parental feelings of competence.

Bertha, the mother of 14-month-old Bernice, complained angrily to the occupational therapist at the

early intervention center. She said that during a recent pediatric outpatient visit the doctors implied that she did not feed her baby enough. She stated that she was not going to return to a place where people thought she was a bad mother.

In our society, children's physical growth is a complicated, value-laden attribute. This is especially the case during infancy, when weight gain is one of the primary foci of pediatric care. Indeed, at the time of delivery, the baby's weight and height are a highlight of what is often the family's first formal communication to society at large—the birth announcement. It is not surprising that parents often experience weight gain as concrete proof of the adequacy of their caretaking abilities (Parmelee, 1989). For this reason, it is generally threatening to parents when someone other than family (e.g., pediatric staff, child welfare worker) is the first to recognize the presence of a growth problem.

Although many parents—approximately 63 percent in two studies (Black et al., 1991; Sturm and Drotar, 1991)—express some concern about child growth when NOFT is diagnosed, a sizeable number also fail to appreciate the signs and symptoms of poor weight gain (Ayoub and Milner, 1985). Black et al. (1991) found that in their NOFT sample, infants perceived as thin by their parents were not in reality thinner than those whose parents inaccurately perceived them to be average. Whether this finding is due to a perceptual bias unique to FTT, especially nonorganic failure to thrive, or represents a compensatory response by parents when faced with the NOFT diagnosis is not clear. However, such results highlight the need to explore with all parents their perception of the child's growth status and the physical and behavioral cues that support their views.

When talking with parents, the diagnostic term "failure to thrive" should be avoided due to the implied criticism of a global deficit in the parents' nurturance and caretaking. Instead, it is advisable to use more neutral and medical terms, like "growth problem" and "difficulty gaining weight," which are less likely to arouse parental feelings of threat, thereby fostering better professional-parent communication.

2. Take the time to inquire in depth about the parents' views of their child's condition.

The degree of the practitioner's knowledge of the patient's explanatory model for his or her medical condition is an important factor in the physician-patient relationship and in effective communication, even when the two individuals' viewpoints differ (Helman, 1988; Squier, 1991). Our experience has been that in pediatric health care settings, staff typically do not ask parents about their health beliefs about their children's illness and symptoms, with the exception of an opening question such as "Why did you bring Jimmy today?" or "What seems to be the problem?" Unfortunately, many parents will not spontaneously volunteer their ideas about the child's condition and will need support to do so. In the hospital setting, we have found it helpful to invite parents to share their ideas about the child's failure to thrive with the following introduction.

To help me understand your child's condition and to plan treatment, I am very interested in your ideas about your child's condition, what may have caused it, what you would like to know about this problem and what kind of help you want for your child. I am also interested in hearing about other family members' opinions about your child's problem. (Drotar and Sturm, 1988, p. 47).

Table 1 presents questions that can be used to explore a parent's health beliefs about failure to thrive.

Table 1

Questions for eliciting parental health beliefs about failure to thrive

1. What do you feel is your child's problem?
2. What do you think might cause such a problem? How might that cause the problem? What else might be a possible cause?
3. How do you feel your child is doing with his/her growth, compared to other children the same age?
4. What do you think might cause a child to have difficulty gaining weight? How would that cause it?
5. How likely do you think it is that your child's problem would get better on its own? How likely is it that it would get worse if it were not treated?
6. What do you think would help your child's problem? How do you think that would help?
7. If nothing were done about the problem, do you think he/she could have any resulting problems in the future?

In addition, asking about a family's prior exposure to and familiarity with babies who have "gone through a period of not gaining weight well" provides a window into parental expectations for the current growth problem. One mother's description of a neighborhood child with failure to thrive included the fact that the child's mother's drug dependence resulted in termination of parental custody. This led to a discussion of her fears that staff would assume that she too was neglectful since her daughter was not gaining weight.

3. Expect the parent to voice a "medical" explanation for their child's poor growth.

Eric and Anne are young parents with three children under the age of five. Their youngest child, Billy, age 10 months, just completed an inpatient admission for poor growth and anemia. The doctor explains that no major medical problems were found. The parents are adamant that their child eats well and that there must be a medical problem that the doctor has not yet discovered.

In order to intervene effectively with parents, we need to involve them in interventions on behalf of their child. When asked, most parents will state that a specific medical or physiological problem is the reason for the child's failure to gain weight. (Sturm and Drotar, 1991; Drotar and Sturm, 1988). How can we understand parents' explanations of their child's NOFT? There are a range of parental explanations for poor weight gain, the most typical being attribution of an illness, condition or structural defect that prevents weight gain (Sturm and Drotar, 1991). Such conditions include food allergies and other "problems with his stomach", as well as more global "flu" and "virus" or frequent "sickness". Prematurity is also used to explain a slow rate of growth.

Other explanations that are encountered include *constitutional* in which the child is viewed as constitutionally or genetically predisposed to be small in size, thin or underweight.

Maria disagrees with her nurse practitioner who feels that her two-year-old daughter Francesca is falling off the growth curve. "She looks like all the people in my family—tall and thin. People say I was like that when I was her age. Besides, she was born early—those babies just take longer to put on weight."

Child behavior explanations refer to child temperament or personality, with explanations about refusal to eat, poor appetite, vomiting for attention, or depression. *Family problem* explanations, the least frequently encountered causal attribution of NOFT parents but the most frequent for pediatric staff, point to interferences by family interactions, maternal emotional problems, family stress or drug/alcohol abuse.

The parents' medical or organic explanation typically conflicts with pediatric staff's diagnosis of the problem as predominantly related to psychosocial factors rather than specific medical causes. Medical causes are probably the least threatening explanation that parents can generate when faced with an anxiety-arousing condition like poor weight gain. In fact, there may well be a parental bias toward explaining child conditions that challenge parental self-esteem by means of medical diagnoses. An example may be the popularity of attention deficit hyperactivity disorder among parents with schoolage children with behavior problems.

In addition to the threat-reduction function of medical causal explanations, there may be an experiential basis to parents' attributions. Many children who fail to thrive have had prior physical illness that probably reinforce parental perceptions of the child as having a medical/physical problem that calls for medical rather than psychosocial treatment (Sherrod et al., 1984). Kotelchuck (1980) reported, for example, that mothers of NOFT preschoolers at the time of hospitalization described them as more sickly than did mothers of children in a comparison group. Medical conditions that can co-occur with NOFT, such as dehydration, diarrhea, anemia, emesis, and increased incidence of respiratory infections, may be perceived by some mothers as the child's primary problem. In our study of maternal causal explanations, 36 percent of the children in the sample had a history of hospitalizations prior to the NOFT admission. Behavioral changes that can



NANCY P. ALEXANDER

accompany malnutrition, such as irritability, lethargy, decreased social responsiveness and decreased appetite, may also be viewed by parents as signs of illness.

4. At the time of diagnosis, staff should be prepared for some degree of disagreement or conflict with parents of NOFT infants.

The context in which NOFT is diagnosed can sometimes contribute to parental confusion, anxiety and manifest anger. When poor growth is first identified at the time of pediatric services for acute illness (e.g., an outpatient sick visit or an emergency room visit) the acute illness symptoms are typically much more of a focus of parental concern than the child's undernutrition. Parents of toddlers with longstanding growth problems, where there may not have been a recent abrupt change in intake, may have particular difficulty appreciating the pediatric concern with growth, given the absence of outward symptoms of illness. In either case, it can be helpful to empathize with the confusion the parent undoubtedly feels but may not feel safe to express. For example we have found it helpful to provide the following explanation to parents of toddlers.

Many parents have told me that they find it confusing or upsetting to hear from a doctor that something is wrong with their child's growth when their child may not show symptoms of illness. You see your child running around, playing, without problems that would lead you to suspect there might be a problem. (Drotar and Sturm, 1988, p. 47).

Professionals sometimes respond counterproductively to signs of parental indifference or anger. They may argue or try to coerce the parent to accept their viewpoint of the problem or they may discredit the parent's opinion or perceptions by silently labeling them as resistant or

emotionally disturbed. In either case, they will be unlikely to explore the parents' views further. For example, parental denial of the presence of a growth problem in an infant may stimulate attributions of mental illness ("That mother must be crazy not to see what everyone else can see.") In addition, practitioners may prematurely judge some parents as neglectful or may inappropriately recommend termination of parental custody.

5. When discussing the child's condition, the focus should be future-oriented and concerned with how staff and parents can work together to improve the child's growth.

Parents are frequently anxious that the outcome of the diagnostic process will be that they will be blamed and found responsible for their child's condition. Placing primary emphasis on the active steps that the parent can take now to help their child in the future can reduce parental guilt, increase parental feelings of control, and communicate support for the parent as a treatment team member. Parents can sometimes accept a recommendation for psychosocial treatment even though they do not totally agree with the staff's diagnosis.

A 17-year-old mother of a severely malnourished 13-month-old was advised to encourage her daughter to eat at mealtimes. This mother perceived such efforts to increase caloric intake as "forcing" her child, and she felt that the baby's poor growth was due to a long resolved heart murmur rather than to "not enough food." This mother was able to accept the professionals' explanation that modifying the interaction between herself and her daughter at mealtimes might help her daughter's growth, even though she continued to frame the cause of NOFT as solely medical. As she said, "I feel it's her body (that is the cause of her failure to

gain weight), not her not eating enough, but if staff will tell me what is enough food, I'll give her that."

We have also found that parents are less threatened by a psychosocial explanation of poor growth if it can be related to their child's individuality and special sensitivities. Suggestions for handling mealtime behavior, caloric intake and general discipline issues can often be reframed as strategies whereby parents can meet their child's special needs more effectively. We have found that terms like child "sensitivity" or "alertness" to stress or family interactions are often interpreted as evidence of our appreciation for the child's unique and positive attributes. This in turn is often experienced by parents as a communication that they have done something right as parents.

Conflicts between staff and parents can be lessened by efforts to understand parents' explanations of the child's condition. We recommend adopting an orientation to treatment planning that capitalizes on Katon and Kleinman's (1981) model of clinical negotiation in medical care. Communications with parents about diagnosis and treatment approaches should be carefully planned, with ample time allotted for an unhurried discussion. After a thorough exploration of parental health beliefs, differences in viewpoints between parents and staff should be openly discussed rather than glossed over or avoided.

In some cases, misconceptions that might affect adherence to treatment recommendations can be directly addressed. For example, Pugliese et al. (1989) described parental fears of obesity, atherosclerosis, and overconcern with a healthy lowfat diet as leading to practices that resulted in inadequate child caloric intake. With nutritional counseling that is tailored to specific misconceptions and concerns, all food restrictions were removed, and in most cases the child's caloric intake improved. Another example is that of older infants and toddlers who exhibit feeding disorders that represent efforts to negotiate issues of separation and individuation from the primary caregivers (Chatoor et al., 1985). In these cases, professionals employ such terms as "behavioral feeding problem" or "feeding disorder." We have found, however, that some parents may overreact to this diagnosis because they confuse developmental feeding problems of the preschool period with adult eating disorders such as bulimia, anorexia nervosa, and obesity. We recently conducted an interview study with urban disadvantaged mothers and found that a sizeable number of mothers view adolescent and adult eating disorders as likely consequences of untreated failure to thrive. Thus, they seem to feel that FTT predisposes a child to an adult eating disorder. At the time of diagnosis, then, it is important for practitioners to allay such parental fears in order to help parents to perceive their child's problems accurately, without undue anxiety that can interfere with participation in a treatment plan to address the child's maladaptive eating style.

When disagreements between parent and staff become apparent, staff would do well to "agree to disagree." This approach avoids discrediting or dismissing summarily the parents' opinions. Whenever possible, negotiating a working compromise between what staff may view as the "optimal" treatment approach and the parent's recommendations should be attempted. This model transforms

treatment regimens from a set of compliance tasks that are prescribed to the parent into a mutual endeavor between multiple treatment team members, one of whom is the parent.

Betty was very distressed by the treatment team's recommendation for an inpatient hospital stay for her nine-month-old daughter Jessica, in order to evaluate more fully her caloric needs and feeding style. The physician explored Betty's thoughts about possible treatment approaches and they were able to agree to postpone the admission until an outpatient trial of weekly pediatric visits for weight checks, nutritional counseling, and occupational therapy feeding evaluation was completed. At the time of the negotiation, Betty agreed to the possibility of pediatric admission in the event that the outpatient interventions proved unsuccessful.

Communications with the parents of children who fail to thrive are seldom easy. However, a concerted effort to understand and respect parents' beliefs about their children's health and physical growth may lessen the burden on practitioners and decrease the likelihood that practitioner-parent miscommunication is an obstacle to effective management of the child's condition. We feel that careful attention to parental health beliefs can improve the parent's experience of practitioner empathy, satisfaction with pediatric care, and commitment to follow-through with treatment recommendations.

References

- Ayoub, C., & Milner, J. (1985). Failure to thrive: Parental indicators, types, and outcomes. *Child Abuse and Neglect*, 9, 491-499.
- Black, M., Dubowitz, H., & Hutcheson, J. (1991, August). Nonorganic failure-to-thrive: Parental perceptions and parental-infant interactions. Paper presented at the meeting of the American Psychological Association, San Francisco.
- Chatoor, I., Dickson, L., Schaefer, L., & Egan, J. (1985). A developmental classification of feeding disorders associated with failure to thrive. In D. Drotar (Ed.), *New directions in failure to thrive: Implications for research and practice* (pp. 235-258). New York: Plenum Press.
- Drotar, D. (1991). The family context of nonorganic failure to thrive. *American Journal of Orthopsychiatry*, 61, 23-34.
- Drotar, D., & Sturm, L. (1988). Parent-practitioner communication in the management of nonorganic failure to thrive. *Family Systems Medicine*, 9, 53-63.
- Helman, C. (1985). Communication in primary care: The role of patient and practitioner explanatory models. *Social Science and Medicine*, 30, 923-931.
- Katon, W., & Kleinman, A. (1981). Doctor-patient negotiation and other social science strategies in patient care. In L. Eisenberg & A. Kleinman (Eds.), *The relevance of social science for medicine*. Boston: Reidel.
- Kotelchuck, M. (1980). Nonorganic failure to thrive: The status of interactional and environmental theories. In B.W. Camp (Ed.), *Advances in behavioral pediatrics* (Vol. 1) (pp. 29-51). Greenwich, CT: JAI Press.
- Parmelee, A. (1989). The child's physical health and development of relationships. In A. Sameroff & R. Emde (Eds.), *Relationship disturbances in early childhood*. New York: Basic Books.
- Pugliese, M., Weyman-Daum, M., Moses, N., & Lifshitz, F. (1987). Parental health beliefs as a cause of nonorganic failure to thrive. *Pediatrics*, 82, 175-182.
- Sherrod, K.B., O'Connor, S., Vietze, P.H., and Altemeier, W.A. (1984). Child health and maltreatment. *Child Development*, 55, 1174-1183.
- Squier, R. (1990). A model of empathic understanding and adherence to treatment regimens in practitioner-patient relationships. *Social Science and Medicine*, 3, 325-339.
- Sturm, L., & Drotar, D. (1991). Maternal attributions of etiology in nonorganic failure to thrive. *Family Systems Medicine*, 9, 53-63.

EARLY START: Nutrition Services in Early Intervention in Massachusetts

by

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Infants and toddlers who are at risk for developmental delay are often at nutritional risk as well. They may experience, for example, oral motor and feeding problems, drug-nutrient interactions, and metabolic disorders. Part H (the infant/toddler section) of the IDEA (Individuals with Disabilities Education Act) appropriately includes nutritionists as one of the key professional disciplines involved in planning, providing, and coordinating early intervention services for infants, toddlers, and their families.

Historically, however, nutrition services for young children at risk of developmental delay have been slow to develop. Obstacles to implementing nutrition services for these children have included: absence of nutrition information, resources, and direct care services for families participating in early intervention; inadequate documentation of the scope and depth of the nutritional risks of this population; lack of knowledge of appropriate roles for nutritionists within the early intervention system; limited training for parents, early intervention providers, and community nutritionists about the importance of adequate nutrition and the identification of children at nutritional risk; and limited access to qualified nutrition service providers.

To address these issues, the EARLY START project in Massachusetts developed a model of nutrition services in early intervention. As a collaborative effort between the Office of Nutrition, Massachusetts Department of Public Health (MDPH) and the Shriver Center, a University Affiliated Program, EARLY START was funded by the federal Maternal and Child Health Bureau from October, 1988 through September, 1992. EARLY START was housed within the MDPH Bureau of Family and Community Health, which, as the Part H Lead Agency, sponsors 49 Early Intervention Programs throughout the Commonwealth. During FY 1991, these programs provided social, educational, and therapeutic services to 8,251 families. EARLY START activities in the six pilot sites funded by the grant included:

- establishing a system of screening, assessment and referral to identify children within Massachusetts' early intervention programs who are at nutritional risk;
- establishing a centralized nutritional data system for the early intervention birth-to-three population;
- nutrition training for early intervention providers and families; and
- addressing reimbursement and financing of nutrition services.

Screening, assessment, and referral

Six pilot early intervention sites, serving a cross-section

of the early intervention population in Massachusetts, were selected to participate in EARLY START. Nutritionists trained in working with children with developmental delays spent one day per week at each site. They screened and assessed children; provided counseling to families; and trained staff and parents. The nutritionists developed a comprehensive two-page screening form (p. 30) and a referral form (p. 31) that early intervention staff could use for identification and referral of children in need of nutrition intervention.

A centralized data system

A central reporting system was established to document the nutritional status of children in Massachusetts' early intervention programs and assess their need for nutrition services. Massachusetts Department of Public Health staff developed a database from the information collected on EARLY START screening/assessment forms, integrated with information from early intervention program registration forms. Nutritionists at the pilot sites used this information to counsel families and to refer them to other community-based nutrition services.

Nutrition training activities

EARLY START staff developed a training module for early intervention providers and families on specific nutritional issues related to infants and toddlers with special needs. The slide presentation and script, available for purchase from Cynthia Bayerl, cover nutrition assessment and intervention related to problems of growth, diet, feeding, drug-nutrient interactions, bowel management, and dental health.

EARLY START was also involved in a number of statewide training activities for early intervention staff, parents, and nutritionists:

Staff training included in-service training and information sharing during child evaluations at the six pilot sites, as well as EARLY START participation in state-level Part H training sessions. Training addressed a broad range of topics including growth, diet and behavior, oral motor and feeding issues, and nutritional concerns related to prematurity, Down syndrome, cerebral palsy, and other conditions.

Parent support/educational workshops at the six pilot sites covered parents' concerns about children's behavior around feeding, food textures, appetite, and diarrhea and constipation. A number of parents raised nutrition-related concerns in the context of developing IFSPs (Individualized Family Service Plans), and options for educating and supporting parents to advocate for nutrition services as part of the IFSP were developed. EARLY START staff tailored activities at each site to parents' concerns. Activities included food fairs, which involved staff and families in preparing and tasting low-cost, nutritious finger foods; taste-testing of high calorie foods and/or dietary supplements; informal question and answer sessions with a nutritionist; a five-week lunchtime series on "How, Why, and When Children Eat"; and bulletin board displays of educational materials on nutrition.

Nutritionist training began with a statewide Nutritionist Resource Survey to determine the availability of nutritionists to work with the birth-to-three population with special

Early Intervention Nutrition Services, Bureau of Parent, Child and Adolescent Health, Massachusetts Department of Public Health, Office of Nutrition, 150 Tremont Street, Boston, MA 02111 (617) 727-5822

To be completed by screener. Refer to protocols for instructions on completing each question. To determine if further assessment is needed, see Nutrition Referral Criteria

1. Screening Date: 1. / /

2. Child's ID No.: 2.

3. Child's Sex: (M) Male (F) Female 3.

4. Date of Birth: 4. / /

5. Birth weight: 5. kgs or lbs. oz

6. Birth Length: 6. cm. or in. 8th

reported by caregiver ☐ or found in medical record ☐

7. Gestational age: 7.

8. Date of measurements 8. / /
9. Weight: 9. kgs **or** lbs. oz.
10. Length/height: 10. cm **or** in. ft.
11. How was the child measured: 11.
1 = standing, 2 = lying down

12. WT/AGE

--	--

 to

--	--

 centile

13. HT/AGE

--	--

 to

--	--

 centile

14. WT/HT

--	--

 to

--	--

 centile

15. Date of Hemoglobin or Hematocrit: 15. / /

16. HEMOGLOBIN 16. gms/100 ml or

17. HEMATOCRIT 17. percent

18. Date of FEP or Lead (PB): 18. / /

19. FEP ug/dl 20. LEAD (PB) ug/dl

— Down Syndrome	— Failure to Thrive	— Cardiac
— Cerebral Palsy	— Fetal Alcohol Syndrome	— Kidney
— Spina Bifida	— Cystic Fibrosis	— Seizure Disorders
— Anemia	— Neuromuscular	— Poor Growth
— Respiratory	— Liver	— Gastrointestinal
— Other (specify) _____		

	YES	NO
22. Does your child have any food allergies?	☐	☐
23. Does your child take any medications on a regular basis? (excluding vitamins, iron, fluoride or other minerals)	☐	☐
(a) If yes, which one(s)? _____		
24. Does your child experience any of the following? (Circle all that apply):	☐	☐
1. diarrhea		
2. constipation		
3. vomiting/reflux		
25. Does your child use a feeding tube or other special feeding equipment?	☐	☐
26. Do any of the following apply to your child at his/her present age? (Circle all that apply):	☐	☐
1. 7 mo. of age or older and has not started using cup yet		
2. 9 mo. of age or older and does not finger feed yet		
3. 12 mo. of age or older and drinks liquids primarily from the bottle		
4. 19 mo. of age or older and does not use a spoon yet		
27. Does your child experience any of the following? (Circle all that apply)	☐	☐
1. difficulty with sucking		
2. difficulty with swallowing		
3. difficulty with chewing		
4. gagging		
28. If your child uses the bottle, does he/she take the bottle to bed?	☐	☐
29. Do you add solid foods to the bottle?	☐	☐
30. If your child is under 12 months, and drinks formula, is he/she drinking less than 24 ounces per day?	☐	☐
31. If your child is over 12 months old, does he/she reject any of the following foods: (Circle all that apply):	☐	☐
1. milk 2. meats 3. vegetables 4. fruits		
32. Does your child do anything that upsets you at mealtimes such as refusing to eat, excessive throwing of food/utensils, or other	☐	☐
(explain): _____		
33. Do you ever find that you are almost out of food at the end of the month?	☐	☐
34. Do you have any questions/concerns about your child's nutrition and feeding? If yes,	☐	☐
specify _____		
35. If you are currently breastfeeding, do you have any questions or concerns? If yes,	☐	☐
specify _____		

health care needs. The survey also identified four priority areas for training special needs nutritionists: screening and/or assessing children with special needs; growth delay and failure to thrive; oral motor and feeding issues; and nutritional guidelines for the premature infant post hospital discharge.

Early intervention teams including EARLY START nutritionists designed and conducted a regional conference on the integration of nutrition services in early intervention. EARLY START nutritionists spoke to WIC and community health center staff on nutritional issues and concerns of children with special health care needs; they also presented their findings at state and regional conferences of dietitians and nutritionists.

Financing nutrition services

The availability and accessibility of nutrition services and products to infants and toddlers depend largely on the payment and reimbursement systems that are in place where they live. EARLY START developed options for addressing financial support of nutrition services by providers and Part H administration, recognizing that both public and private reimbursement sources will be needed to assure the availability of nutrition services. EARLY START information, tools, and proposed recommendations were shared regularly with the New England Nutritionists for Children with Special Health Care Needs (NEN). The goal of this group, which consists of professionals who provide a wide range of nutrition counseling and education services, administrators, trainers, and policymakers, is to develop a regional training plan and activities for nutritionists to work with children with special needs.

An ongoing effort

The EARLY START project was designed to develop a model of nutrition services for infants and toddlers in early intervention programs who were at risk or potentially at risk for developing nutritional problems. The data gathered at the six pilot sites were intended to provide a "descriptive epidemiology" suggestive of the need for nutrition services in this population, as well as a sense of the staff and funding levels that would be required to provide such services. Through its formal data collection, training activities, and direct services, EARLY START gained enormously valuable understanding of the relationships between nutritional needs and interventions and early intervention services.

As a result of EARLY START, Massachusetts and other New England states have begun to address how each state will integrate nutrition services into its early intervention system for infants, toddlers, and their families. In Massachusetts, Office of Nutrition staff continue to work with early intervention staff and programs to integrate the EARLY START findings and recommendations into the operations and staff development activities of all early intervention programs across the Commonwealth.

Additional information on the EARLY START Project, including copies of tools used, findings of a survey of state agency special needs nutritionists, project reports, and the training manual and slides are available from Cynthia Taft Bayerl, Co-Principal Investigator, Office of Nutrition, Bureau of Family and Community Health, Massachusetts Department of Public Health, 150 Tremont Street, Boston, MA 02111, tel: (617) 727-5822.

Early Intervention Nutrition Referral Criteria

Place a check mark in the "Yes" column next to the nutritional risk that applies to the child

If ONE or more of the following apply, refer child to a nutritionist/R.D. for further assessment. If you need assistance in locating a qualified nutritionist, contact the Office of Nutrition at the Massachusetts Department of Public Health, (617) 727-5822.

Yes

- ☐ Weight for age is below the 10th percentile
- ☐ Length/height for age is below 10th percentile
- ☐ Weight/length or height is below the 10th percentile
- ☐ Weight for length/height is above the 95th percentile
- ☐ Hemoglobin: 11gms/dl or LESS
- ☐ Hematocrit: 34% or LESS
- ☐ FEP: 35ug/dl or GREATER
- ☐ Lead (Pb): 10ug/dl or GREATER

☐ Child has any of the following diagnoses and/or chronic medical conditions:

Down Syndrome	Cardiac	Failure to Thrive
Cerebral Palsy	Seizure Disorder	Cystic Fibrosis
Fetal Alcohol Syndrome	Gastrointestinal	Anemia
Spina Bifida	Respiratory	Liver
Neuromuscular	Poor Growth	Kidney

OR If TWO or more of the following apply, refer child to a nutritionist/R.D. for further assessment.

Yes

- ☐ History of food allergies.
- ☐ Medications taken on a regular basis.
- ☐ Chronic problems with diarrhea, constipation, and/or vomiting/reflux.
- ☐ On a feeding tube and/or special feeding equipment.
- ☐ Any of the following feeding skill delays:
 1. 7 mo. of age or older and has not started using cup yet
 2. 9 mo. of age or older and does not finger feed yet
 3. 12 mo. of age or older and drinks liquid primarily from the bottle
 4. 19 mo. of age or older and does not use a spoon yet
- ☐ Difficulty with sucking, swallowing, chewing, or gagging.
- ☐ Bottle to bed (night-time or nap time).
- ☐ Solids (i.e. cereal, fruits, etc) added to the bottle.
- ☐ Formula intake is less than 24 ounces in 24 hours (for infants 0-12m)
- ☐ Meals regularly lack one or more of the basic foods (meat, milk, fruits or vegetables)
- ☐ Mealtime behavior frustrating to parent.
- ☐ Lack of food in household to meet child/family's needs
- ☐ Nutrition and/or eating habits of child is a concern of parent/caregiver.
- ☐ Breastfeeding questions or concerns of parent.

Early Intervention Nutrition Services, Bureau of Parent, Child and Adolescent Health, Massachusetts Department of Public Health, Office of Nutrition, 150 Tremont Street, Boston, MA 02111 (617) 727-5822.

Working Together For Breastfeeding Success

By

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In 1979, the US Department of Health, Education and Welfare set ten year health objectives for the nation. These included an increase in the rate of breastfeeding at hospital discharge from 45 to 75 percent and at six months from 21 to 35 percent. Despite the multiple efforts undertaken throughout the 1980s to support breastfeeding as a maternal choice, these target goals were not reached. Revised goals were set by the Department of Health and Human Service's "Healthy People 2000: National Health Promotion and Disease Prevention Objectives". These are a 75 percent rate of breastfeeding in the early postpartum period and 50 percent at six months. Breastfeeding rates in this country have varied from a low of approximately 25 percent in the 1950s and 60s to a high of about 65 percent in the 1970s and 80s. Unfortunately, the incidence of breastfeeding is again waning.

However, we do have evidence of numerous factors that influence positively the decision to breastfeed and contribute to its ultimate success. The importance of having strong supportive services available to women as they make decisions on methods for feeding their child and as they attempt to breastfeed seems clear. The media, government agencies, multiple professionals and other supports all can play a role in promoting breastfeeding. Lactation Consultants can offer specialized assistance to mothers when difficulties or problems with breastfeeding arise. Supports to individual women can now be seen in the context of multiple national and international initiatives geared toward the promotion of breastfeeding as the preferred method of feeding infants for a healthy start in life.

The decision to breastfeed

A woman's choice of feeding method for her child is often made before conception and almost always before the end of the first trimester of the pregnancy (Aberman, 1985; Sarett, 1983). It is shaped by attitudes formed much earlier, often in childhood, through imitation of parental behaviors and through childhood play activities. Nurses, physicians, childbirth educators, and lay support groups are important influences on feeding choice, but not as important as the mothers' friends and relatives. The new mother's own mother and husband usually play the biggest role in her decision.

Since children's attitudes may be shaped by TV and movie depictions of feeding situations, television advertising recently begun by infant formula manufacturers may influence future generations as well as present-day women by presenting a notion that formula feeding is more convenient and glamorous than breastfeeding. Articles in magazines with broad circulation and books for the general public also play a role (Aberman; Kaufman & Hall, 1989).

Researchers have found that the primary reasons women choose breastfeeding are: protection of the infant against infection, bonding, convenience, and better nutrition (Ekwo, 1983). Family life educators and health care professionals can emphasize and reinforce these reasons before conception and during pregnancy. Videos and pamphlets that promote breastfeeding are available at low cost (National Center for Education in Maternal and Child Health, 1992). Some supporters of breastfeeding are concerned that videos and pamphlets produced by infant formula manufacturers, and often distributed in physicians' offices and hospitals, may undermine mothers' decisions to breastfeed.

Increasing the likelihood of breastfeeding success

Once women make the choice to breastfeed, ongoing information and support are critical to the success and duration of breastfeeding. Several approaches have had demonstrated effectiveness:

- Prenatal breastfeeding classes (Wiles, 1984; Kistin, 1990).
- Early contact with the infant after birth (Bernard Bonnin, Stachtchenko, Gird & Rousseau, 1989; Righard, 1990);
- Minimal medication during delivery (Righard, 1990); and
- Timing of the first feeding and rooming in (Wright, 1983; Feinstein, 1986).

Factors which have been shown to have a negative influence on the success of breastfeeding include: supplementation with formula (Wright, op.cit.; Feinstein, 1986); mothers' fear of insufficient milk (Morgan, 1986); separation of mother and baby even for a short time (Elander, 1984); issues of maturity and self-esteem, role models, ambivalence of health care providers, maternal fatigue, infant fussiness (Kearney, 1988); lack of prenatal care (Grossman, 1990); maternal lack of confidence and prolonged infant crying (Loughlin, 1985).

Successful breastfeeding depends on the complex interaction of many physical, emotional, educational, and social factors. Breastfeeding support programs should consider and address all of these factors.

Organized strategies and services to support breastfeeding

Support in the hospital during the critical time of establishing breastfeeding patterns is indispensable. Early initiation of breastfeeding, during the birth recovery period, is ideal. Infants are most ready to begin sucking instinctively during the first two hours after birth. Advantage should be taken of this favorable period, even for mother's with cesarean sections.

A breastfeeding guide, such as the one depicted on page 33, is useful in observing infants at the breast to determine proper positioning and in detecting problems that need to be resolved or referred for follow-up. Such follow-up can be to a Lactation Consultant or to lay support group such as a La Leche League or Nursing Mother's Council.

B-R-E-A-S-T feeding Observation Guide

Correct

Errors

Body position

"Belly to belly"
Baby horizontal at mom's waist
Close to mom
Neck straight or extended
Chin on breast, nose unobstructed

Baby lying flat on back
Baby's feet in mom's lap
Body distant from mom, arms in the way
Neck flexed
Chin away from breast, nose obstructed

Responses

Calm & alert at breast
Rooting reflex
Homing-in response
Signs of let-down
dripping
tingling

Restless, fussy
No rooting reflex
No homing-in response
No let-down

Emotional bonding

"En face" attention from mother
Much touching, talking
Secure hold on baby

No eye contact
Minimal touching, talking
Loose, limp, shaking hold

Anatomy

Breasts soft
Nipples erect and protractile
Skin intact

Engorgement
Nipples flat or inverted
Cracks, blisters, pain

Suckling

Mouth WIDE open
Rhythmic burst-pause suck-swallow
Tongue over lower gums
Cheeks plump

Mouth partially open or lax
Fluttering, clicking, long rests
Tongue not visible
Cheeks drawn in, dimples

Time

10-15 minutes per breast
Feeding every 2-3 hours
Feeding around the clock

Less than 10 minutes
Intervals more than 4 hours
Skipping feedings

(Adapted with permission from an original by Helen Armstrong, IBFAN, Africa, Nairobi, Kenya.)

Hospital-to-home care continuity is essential for breastfeeding support since hospital stays for delivery are now shorter, usually 24-48 hours, allowing only limited time for guidance.

Unintentional "modeling" of bottle feeding by hospital nursery personnel may be an action that speaks louder than words (Reiff, 1985). Researchers have found that virtually all mothers who switched from breast to bottle feeding used the brand of infant formula that was used in the hospital. Discharge formula gift packages correlate with shorter duration of breastfeeding (Evans, 1986; Bergevin, 1983; Frank, 1987). The underlying message of giving a breastfeeding mother a formula sample is, "You will need this". This message can discourage a mother who experiences any difficulties in initiating breastfeeding from continuing her efforts.

As more and more women with children under one year of age return to work, the workplace can have

a significant role in supporting or discouraging long term breastfeeding. To encourage long term breastfeeding, employers need to provide breaks and privacy for mothers to maintain lactation. Ideally the infant would be in child care at or near the work site so the mother could breastfeed during working hours. If this is not possible, private rooms should be available for mothers to pump their breasts once or twice during the workday so the breastmilk can be provided to the child care provider for feedings (Reifsnider, 1985). The employer can supply an electric breast pump that can be shared among all lactating mothers by using individual pumping kits, or mothers can use their own pumps.

The role of Lactation Consultants

A new allied health care worker has arisen out of the need for expert intervention when a breastfeeding problem arises. Lactation Consultants are professionals,

usually nurses, physical therapists, or dietitians, with additional training and experience. They offer advice on problems ranging from sore nipples to suckling disorders. Lactation Consultants also serve on interdisciplinary teams that address more complex problems, such as failure to thrive.

Lactation Consultants work in a variety of settings, ranging from public and private clinics to hospitals, physicians' offices, and their own private practices. They provide education and expert assistance to new mothers experiencing difficulties in breastfeeding. Lactation Consultants also serve frequently as staff educators and as a resource in program planning (Auerbach, 1985; Jones, 1986; Naylor, 1987).

Lactation Consultants can receive their specialized training at a number of places. The UCLA extension offers a week-long Lactation Educator Program. Georgetown University Hospital's National Capital Lactation Center offers a Lactation Consultant Training Program twice a year in Washington DC. The Lactation Institute in Encino, CA offers Lactation Training as well as a Master's Degree program in Human Development with a specialization in Lactation through Pacific Oaks College. The La Leche League offers traveling workshops throughout the country.

Certification for Lactation Consultants has been available through the International Board of Lactation Consultant Examiners for the past six years. Persons meeting the prerequisites may sit for the certification exam offered every July at several sites throughout the world. Those who pass the exam may use the designation International Board Certified Lactation Consultant (IBCLC) after their name.

The International Lactation Consultant Association is the professional organization for Lactation Consultants and holds an annual conference. The Journal of Human Lactation, the official publication of the association, contains practice- and research based articles on lactation and breastfeeding.

Government and organizational support for breastfeeding

Community, national, and international support for breastfeeding is taking many forms. These include development of practice codes, training of professionals and paraprofessionals, development of educational materials for parents, establishment of milk banks, and ongoing, multifaceted organizational support. Examples of numerous current initiatives include:

- **Healthy Mothers, Healthy Babies** is a national coalition, with state and local affiliates, of organizations working together for maternal and child welfare. The coalition's subcommittee on breastfeeding is currently working on promoting breastfeeding in the workplace.

- **The World Health Organization (WHO)** has established a Code of Marketing Breastmilk Substitutes designed to limit the promotion and advertising of proprietary formula. All nations belonging to the UN-World Health Assembly signed the code except the United

States. WHO has also published a "Ten Step Plan for Hospitals" to assist hospitals in evaluating the support they give breastfeeding (World Health Organization, n.d.).

Ten Steps to Successful Breast-feeding

Every facility providing maternity services and care for newborn infants should:

1. Have a written breast-feeding policy that is routinely communicated to all health care staff.
2. Train all health care staff in skills necessary to implement this policy.
3. Inform all pregnant women about the benefits and management of breast-feeding.
4. Help mothers initiate breast-feeding within a half-hour of birth.
5. Show mothers how to breast-feed, and how to maintain lactation even if they should be separated from their infants.
6. Give newborn infants no food or drink other than breast milk, unless medically indicated.
7. Practice rooming-in—allow mothers and infants to remain together—24 hours a day.
8. Encourage breast-feeding on demand.
9. Give no artificial teats or pacifiers (also called dummies or soothers) to breast-feeding infants.
10. Foster the establishment of breast-feeding support groups and refer mothers to them on discharge from the hospital or clinic.

From: **Protecting, Promoting and Supporting Breast-feeding: The Special Role of Maternity Services**

A Joint WHO/UNICEF Statement

Published by the World Health Organization
1211 Geneva 27, Switzerland

- **UNICEF (the United Nations Children's Fund)** recently embarked on an initiative for "Baby-Friendly Hospitals" which promotes mother/infant togetherness, early and frequent breastfeeding, elimination of supplemental bottles and encouragement for consumers to evaluate their health care facilities. August 1 has been designated World Breastfeeding Day to celebrate the importance of breastfeeding.

- **WellStart**, a lactation clinic and international training program in San Diego, California, trains teams of health care workers from hospitals around the world to go back to their hospitals and reorganize practices to provide expert breastfeeding support. The **Institute for Reproductive Health** at Georgetown University Medical Center, Washington, D.C., originates programs in developing countries for breastfeeding promotion and support, in an

effort to use the natural effect of breastfeeding as a method of child spacing.

• Seven Milk Banks throughout the United States operate similarly to blood banks. They supply pasteurized breastmilk from well-screened volunteer donors on physician's prescription to infants who need the benefits of human milk and whose mothers are unable to breastfeed.

Summary

Working toward breastfeeding success for all mothers and infants demands comprehensive efforts within supportive environments. Efforts should include: fostering positive attitudes toward breastfeeding from childhood on; professional advocacy for breastfeeding; comprehensive parent education and support services; specialized intervention from a qualified professionals when needed; and governmental and private sector policies and practices that support breastfeeding as part of a healthy start for all children.

References

- Aberman, S. Kirchhoff, K. Infant-feeding Practices, Mothers' Decision Making. *JOGNN* Sept/Oct 1985.
- Anderson, GC. Risk in Mother-Infant Separation Post-birth. *Image* 21:4, 196-199, 1989.
- Auerbach, K. The Influence of Lactation Consultant Contact on Breastfeeding Duration in a Low-income Population. *Nebraska Medical Journal*, Sept, 341-346, 1985.
- Barr R, Elias M. Nursing Interval and Maternal Responsivity: Effect on Early Crying. *Pediatrics* 81:4, 529-536, 1988.
- Bergevin Y, et al. Do Infant Formula Samples Shorten Duration of Breastfeeding. *Lancet* May 21:1148-1151, 1983.
- Bernard-Bonnin AC, Stachtchenko S, Girard G, Rousseau E. Hospital Practices and Breastfeeding Duration: A Meta-Analysis of Controlled Trials. *Birth* 16:2, 64-66, 1989.
- Coreil J, Murphy J. Maternal Commitment, Lactation Practices, and Breastfeeding Duration. *JOGNN* July/Aug 1988.
- Ekwo E, Dusdieker L, Booth B. Factors Influencing Initiation of Breastfeeding. *Am J Dis Child* 137, 375-377, 1983.
- Elander G, Lindberg T. Short Mother-Infant Separation During First Week of Life Influences the Duration of Breastfeeding. 73, 237-240, 1984.
- Evans C, Lyons N, Killien M. The Effect of Infant Formula Samples on Breastfeeding Practice. *JOGNN* Sept/Oct, 401-405, 1986.
- Feinstein J, Berkelhamer J, Gruszka ME, Wong C, Carey A., Factors Related to Early Termination of Breastfeeding in an Urban Population. *Pediatrics* 78:2, 210-215, 1986.
- Frank DA, Wirtz S, Sorenson J, Heeren T. Commercial Discharge Packs and Breast-feeding Counseling: Effects on Infant-feeding Practices in a Randomized Trial. *Pediatrics* 80:6, 845-54, 1987.
- Grossman L, Harter C, Sachs L, Kay A. The Effect of Postpartum Lactation Counseling on the Duration of Breastfeeding in Low-income Women. *AJDC* 144, 471-474, 1990.
- Jones D, West R. Effect of a Lactation Nurse on the Success of Breastfeeding: A Randomized Controlled Trial. *J of Epidemiology and Comm Health* 40, 45-49, 1986.
- Kaufman K, Hall L. Influences of the Social Network on Choice and Duration of Breast-feeding in Mothers of Preterm Infants. *Research in Nursing and Health* 12, 149-159, 1989.
- Kearney M. Identifying Psychosocial Obstacles to Breastfeeding Success. *JOGNN* Mar/Apr, 98-104, 1988.
- Keefe M. The Impact of Infant Rooming-In on Maternal Sleep at Night. *JOGNN* Mar/Apr, 122-126, 1987.
- Keefe M. Comparison of Neonatal Nighttime Sleep-Wake Patterns in Nursery Versus Rooming-In Environments. *Nursing Research* 36:3, 140-144, 1986.
- Kistin N, Benton D, Rao S, Sullivan M. Breastfeeding Rates Among Black Urban Low-income Women: Effect of Prenatal Education. *Pediatrics* 86: 741-46, 1990.
- Klaus M. The Frequency of Suckling, A Neglected But Essential Ingredient of Breastfeeding. *Obstetrics and Gynecology Clinics of North America*. 14:3, 623-63, 1987.
- Loughlin H et al. Early Termination of Breast-Feeding: Identifying Those at Risk. *Pediatrics* 75:3, 508-513, 1985.
- Morgan J. A Study of Mothers' Breastfeeding Concerns. *Birth* 13, 104-108, 1986.
- Morse J. Bottorff J. Intending to Breastfeed and Work. *JOGNN* Nov/Dec: 493-500, 1989.
- Naylor A, Wester R. Providing Professional Lactation Management Consultation. *Clinics in Perinatology* 14:1, 33-38, 1987.
- Reiff M, Essock-Vitale S. Hospital Influences on Early Infant Feeding Practices. *Pediatrics* 76, 872-879, 1985.
- Reifsnider E, Myers S. Employed Mothers Can Breast-feed, Too! *Mat Child Nursing* 10:256-259, 1985.
- Righard L, Alade M. Effect of Delivery Room Routines on Success of First Breast-feed. *The Lancet* 336, 1105-1107, 1990.
- Sarett HP et al. Decisions on Breast-feeding or Formula Feeding and Trends in Infant Feeding Practices. *Am J Dis Child* 137, 719-725, 1983.
- Shrago L, Bocar D. The Infant's Contribution to Breastfeeding. *JOGNN* 19:3, 209-215, 1990.
- Wiles, L. The Effect of Prenatal Breastfeeding Education on Breastfeeding Success and Maternal Perception of the Infant. *JOGNN* Jul/Aug, 253-257, 1984.
- World Health Organization. Protecting, Promoting and Supporting Breast-feeding: The Special Role of Maternity Services. Geneva, Switzerland: WHO.
- Wright JH and Walker, PC. Prediction of duration of breastfeeding after primiparous birth. *Journal of Epidemiology and Community Health*, 37, 89-94, 1983.

The United States Committee for UNICEF (United Nations Childrens Fund) maintains an Office of Public Policy and Government Relations in Washington, D.C. One major activity of the office is promotion of the Baby Friendly Hospital Initiative. Susan Silveus, Assistant Director of the Office, notes that "any real increase in the number of mothers breastfeeding in the United States will not only improve the health of U.S. babies, but will also be an important signal to mothers and healthcare workers in the developing world, who often look to the United States for an example, that breastfeeding really is best."

For information about the initiative and a copy of the pamphlet, *Take the Baby-Friendly Initiative!*, contact Susan Silveus, United States Committee for UNICEF, Office of Public Policy and Government Relations, 110 Maryland Avenue, N.E., Box 36, Washington, DC 20002, tel: (202) 547 7946, Fax: (202) 543-8144.

The "Nursing-Working Dilemma": How Health Professionals Can Make A Difference

by
Lydia Furman, M.D.
Cleveland Heights, Ohio

Prospective parents, especially mothers, may ask health professionals for advice on the "nursing-working" dilemma. Aware of medical recommendations promoting breastfeeding, many of them at the same time are experiencing strong social, economic and often conflictual emotional pressures for the mother to re-enter the labor force as early as 4-6 weeks post-partum. The health professional can help the parents clarify their concerns, and ideally, can also enable them to recognize their own and their infant's mental health needs. Effective counseling is usually part of an ongoing relationship between the professional and the parent, because there are no quick and easy answers, and because parents grow, mature and change as they parent their infants. The professional's role is far from trivial: a mother's decisions about nursing and working affect not only herself as a person, a wife and a mother, but also her infant's growth and development, and their precious shared relationship. To the extent that the father supports her, and makes her work at home or away possible, his role in these decisions is important, too.

The most frequently asked first questions are, "Should I breastfeed?" and "Can I still go back to work full-time?" The easiest answer is "yes," followed by advice on pumping techniques and milk storage. It may be more helpful, though, to take a step back and focus first on the parent-child relationship, since these initial questions often encompass or represent other less easily articulated concerns. A professional might respond, "I'm glad you're thinking about how to feed your baby, and about how to work things out with the baby and your job (career). Let's talk about breastfeeding, and about what full-time employment might mean for your baby, for you, and for you both as a couple." The approach offered here is biased toward the presumed mental and emotional health needs of the developing infant. It also, I hope, encourages parents to think for themselves, offers emotional support for the mother, and provides practical advice.

How important is it to breastfeed the baby?

Mother's milk appears to offer clear nutritional and immunologic benefits over commercial formulas. Exactly how much breastmilk and over what time period it is best given in order to provide these benefits is not strictly established. Parents need to know, however, that babies not only thrive but grow and develop normally and beautifully on commercial formulas. Almost without

exception, in developed countries, mother's milk is not lifesaving. Parents can be reassured that, from the baby's viewpoint, it's familiarity of taste (whichever milk is chosen) and, much more importantly, of the nourishing person, i.e. the loved one, that count. In fact, *who* is nurturing, and how, is infinitely more important than what is offered. Realizing that breastmilk is not a magical panacea can help alleviate guilt in mothers who either do not wish to nurse or who cannot nurse for medical reasons, and more importantly, may permit parents to shift focus from *which* milk should be offered, to the nurturing relationship. Either breastmilk or formula is nourishment for the baby's body and soul when given in a consistent and tender way by the same loving person, or, when absolutely necessary, by a familiar substitute.

Is there any problem with full-time employment?

It is important to understand that full-time employment for the mother means full-time separation for the mother and infant. "Nine to five" is a time period that is likely to routinely exceed the infant's (and possibly the toddler's) mental capacities for loving remembering. For the adult this length of time is a standard and tiring workday, but does not usually exceed the adult's cognitive ability to remember, think about, and miss a loved one. Significantly, though, a normal mother who is able to be in touch with her infant's feelings can experience great distress with just these daily extended separations. "Nine to five" also means full-time infant daycare, and usually at least one, if not several, other caregivers. We do not yet know whether having more caregivers leads to either a decreased attachment to each one, or to a decreased ability to attach (i.e. to make relationships) in the longterm. Parents can be urged to think about these issues and to realize that the separation aspect of full-time employment is a parent-child issue worthy of thoughtful consideration in its own right, apart from financial, nutritional, or other concerns.

Is there a big difference between breastmilk in a bottle and breastmilk from the breast?

Here we as professionals need to be honest with ourselves and parents and have the courage to answer "yes." By definition, lactation is "the secretion of milk by a mammary gland," while nursing is "to give milk from the breast to an infant ... to bring up; rear ... to cause to continue, grow or develop." Our answer is not complete if we say "no," or offer only technical advice on lactation, i.e. the various techniques needed to maintain a milk supply whether or not the baby is at the breast. Breastmilk in a bottle from (even the kindest) mother substitute provides, strictly speaking, the same milk, but an entirely different experience, relationship, and nurturing person(s). During full-time nursing at the breast, the synchronization of baby's hunger and mother's let-down provides the physical bias for the closeness and gratification of the nursing relationship; this sort of intimacy and reciprocity is clearly not a function of the milk itself. In order to help parents sort out their thoughts and feelings we need to differentiate breastmilk in a bottle from nursing at the breast because it offers another opportunity to refocus on the parent-child relationship.

Acknowledgements: I greatly appreciate the careful editing and thoughtful suggestions of Dr. Peter Blos, Jr., Joan Blos, and Erna Furman.

How long are you supposed to breastfeed?

This is a difficult question, because ideally the answer is up to the baby whose responsive mother is closely tuned to his cues and signals. Duration of breastfeeding is often used as a quantitative measure of the success of combining lactation and full-time employment. Actually, the quality of the ending, i.e. how weaning went, is probably more important for the baby's and mother's mental health than the precise length of time that breastfeeding lasted. Weaning is a special and challenging developmental step for mother and baby that can begin as early as 5 months of age. Permitting the baby to reject the breast and supporting his growing up and away into a separate person is something a mother can facilitate only when she is physically present most of the time. Pumping milk until the baby is a certain age, or until one is tired of it, unfortunately bypasses this developmental step entirely. Discussions about how long breastfeeding can or ought to last should include the opportunity for parents to learn about the potential significance of weaning, what makes it possible, and when it can be lost.

Why can't I do it all? Other mothers do!

The superwoman myth is a tough nut to crack. A mother who is at home with her infant all day suffers from exhaustion and often feels "stir crazy." The mother who is separated from her infant all day is also exhausted (especially if she is pumping breastmilk), and if she is in touch with her infant's feelings, suffers the anxiety of constantly seeking to bridge the distance between herself and the baby. Much of the superficial information that is available to parents promulgates the myth that a mother with a small baby can and should "do it all," and will thus become happy and satisfied. In reality, of the very few studies available, one group recently found that maternal employment was "significantly associated with cessation of breastfeeding as early as two to three months post-partum," which does not support our society's fantasies on the subject. As professionals we need to let parents know that mothering a baby is a very difficult full-time job, one that is completely worthy of respect in and of itself.

Finally, professionals can address practical issues with parents. We can advocate creative solutions, like longer maternity leaves, flexible part-time hours, and work at home. Mothers need to know that although employers are unlikely to offer alternatives, firm and insistent pressure can often succeed. If it does not, another employer, a different job, or self-employment, in addition to rebudgeting and reprioritizing to stay at home, are other options. At these difficult times the father's support of the mother is crucial: she needs to hear from him that she is a worthwhile and competent person, and irreplaceable as a mother, despite her greatly reduced or non-existent paycheck and lack of visible outside-world accomplishments.

As professionals we should feel successful if parents can begin to think about what is optimal for the baby as a person, and what might be best for the parent-child relationship, as they struggle with the "nursing-working



LOIS BARCLAY MURPHY

dilemma". When these considerations are foremost in the parents' minds, all variety of compromises, solutions, and sacrifices if need be, become possible. Certainly many parents will have difficulty accepting, understanding or implementing this approach. The professional then needs to remain invested in the family, and to refocus efforts on concrete and specific interventions that promote empathizing and staying in touch with the infant. Daily lunch time visits, and providing the baby with something that really smells of mother (like an unwashed t-shirt) with which to nap and be comforted by caregivers, are two examples. Professionals can and should provide more than short-term, technical advice about breastfeeding. Thought-provoking guidance offered on an ongoing basis, that is directed toward promoting the infant's long-term mental health, can be both supportive and nonjudgmental.

References

- Gielen, AC, Faden, RR, O'Campo, P, Brown, CH, Paige, DM (1991). Maternal employment during the early postpartum period: effects on initiation and continuation of breastfeeding. *Pediatr.* 87:298-305.

Zero to Three Notes

[formerly NATIONAL CENTER NOTES]

by Eleanor S. Szanton

We are pleased to announce a new name for our organization:

ZERO TO THREE

National Center for Clinical Infant Programs

This may seem like a small change, particularly as this bulletin, *Zero to Three*, is our best known product. To us, the change is a large one. It allows us to reach out, without making complicated explanations or incurring feats of memory, to individuals and groups who should better understand and share our mission and our message. At the same time, the new name preserves an important part of our history and present identity—for us and to a great many others who know us well.

* * * * *

I am pleased to announce the selection of the Zero to Three/National Center Fellows for 1992-93.

New Fellows are:

- **Linda S. Butler, M.S.W.**, special education and social work, University of Illinois
 - **Robert Blair Clyman, M.D.**, child psychiatry, George Washington School of Medicine
 - **Maria P. Fracasso, Ph.D.**, developmental psychology, National Institute of Child Health & Human Development
 - **Mary P. Grattan, M.S.**, physical therapy, University of Chicago
 - **Dorothy Henderson, M.S.W.**, clinical social work, New York University
 - **Ami Klin, Ph.D.**, clinical psychology, Yale Child Study Center
 - **gretchen Lawhon, M.S.N.**, nursing/clinical therapeutics, University of Washington
 - **Miriam Judith Voran, M.A.**, clinical psychology, University of Virginia
- Fellows returning for a second year are:
- **Gina Barclay-McLaughlin, M.S.**, educational psychology, University of Michigan
 - **Constance Smith Garner, M.S.N.**, special education, George Washington University
 - **Jane Colleen Grady, M.A.T.**, child development, Erikson Institute
 - **Brenda Patricia Jones, M.S.W.**, clinical/developmental psychology, Yale University
 - **Daniel Harry Silver, B.A.**, clinical psychology, University of California at Berkeley

• **Mary Elizabeth Lee Tidmarsh, M.D.**, child psychiatry, McGill University

• **Ellen Elizabeth Whipple, Ph.D.**, social work, Michigan State University

• **Yvette Ellen Yatchmink, M.D., Ph.D.**, pediatrics and developmental psychology, University of Massachusetts

These sixteen highly qualified individuals come from ten disciplines that work with infants and toddlers and their families, and from thirteen institutions throughout the United States and Canada. An impressive number of the Fellows have done academic work in more than one discipline.

We feel very privileged to have been able to maintain our Fellowship program over a period of years, most recently thanks to the generous support of the van Ameringen Foundation and other donors who give us general support. Almost all members of the growing group of graduate Fellows, now more than 100 strong, remain in close touch with us and participate in many of our ongoing activities. Their passion for the provision of better services for infants and toddlers and their families—through improved practice and increased public understanding of the need for services—is very impressive. It is a gift to a host of children who are, and one day will be, ZERO TO THREE.

Publications:

Eating and Growth Disorders in Infants and Children (Developmental Clinical Psychology and Psychiatry Series, Vol. 24, 1991) - Joseph L. Woolston (SAGE Publications, Inc., 2455 Teller Road, Newbury Park, CA 91320) \$14.95.

Eating and growth disorders of infancy and early childhood represent, according to Joseph Woolston, a final common pathway of diverse contributions that include genetics, congenital factors, infant parent relationships, physical, psychological, cognitive, developmental, family functioning, and social issues. In turn, the resultant eating disorder may exacerbate some or all of the initiating problems as well as cause new and even more maladaptive disturbances. Woolston discusses the natural history, diagnostic classification, and treatment issues related to failure to thrive, psychosocial dwarfism, rumination, pica, obesity, benign nutritional dwarfing, and prepubertal anorexia nervosa. He advocates assessment and treatment of eating disorders in the context of a multidisciplinary team approach, noting that "engagement of the family is the most important variable in successful treatment."

Nutrition in Public Health: A Handbook for Developing Programs and Services (1990) - Mildred Kaufman (Aspen Publishers, Inc., 1200 Orchard Ridge Drive, Suite 200, Gaithersburg, MD 20878) \$58.00.

This handbook is designed to define and describe the scope of public health nutrition and the potential opportunities for nutrition services in health agency programs. Many of the issues addressed concern management

and personnel, and the nutritional needs of people throughout the lifespan are considered. A chapter on serving women, infants, and children discusses nutritional care for pregnant women, describes ways to promote and support breastfeeding, discusses anticipatory guidance for parents in feeding their infants and children, describes nutrition services for children with special health needs, and lists and describes the roles of public health nutrition personnel in maternal and child health services.

MCH Program Interchange: Focus on Nutrition (March, 1992) - National Center for Education in Maternal and Child Health (NCEMCH, 2000 15th Street North, Suite 701, Arlington, VA 22201).

This issue of *MCH Program Interchange* includes information about current goals, interests, and product developments in Maternal and Child Health Bureau nutrition services and programs, as well as materials from state and local agencies. The activities of the expanding Maternal and Child Health Interorganizational Nutritional Group (MCHING) are described. The materials reviewed include, among others, the second follow-up report on the Surgeon General's Workshop on Breastfeeding and Human Lactation; a handbook on maternal and infant nutrition bilingual counseling; a three-part videotape developed in Texas for training WIC staff to promote breastfeeding; and *Chocolate Milk in Perspective*, published by the National Dairy Council.

Early Childhood Education: Policy Issues for the 1990s (1992) - Dolores A. Stegeline (ed.) Ablex Publishing Corporation, 355 Chestnut Street, Norwood, NJ 07648) \$42.50, hardcover, \$24.50, paper.

This policy text is designed to serve as a tool for students in child development and early education, children's advocates, legislators, and policymakers in state and national agencies. Among the contributors are Sharon Lynn Kagan, Robert Cervantes, Lawrence Schweinhart and David Weikart, Helen Blank, Ellen Galinsky, Thomas Schultz, Stacie Goffin, Karen Gallagher and R.J. Pat Gallagher, and Dolores A. Stegeline and Peggy Elgas. In a chapter on state policy related to disadvantaged and at-risk preschoolers, Governor Bill Clinton calls for "a good network of primary health care"; state action "to make sure that child care workers are trained and that every center has a strong educational component"; greater partnerships with businesses to expand their employees' child care options; and a system of parental leave for infant and sick-child care. Discussing issues related to infant child care policy, Eleanor Stokes Szanton emphasizes the importance of appropriate training for caregivers as a key to improved quality of child care for infants and toddlers.

Ready To Learn: A Mandate for the Nation (1991) - Ernest L. Boyer (The Carnegie Foundation for the Advancement of Teaching; available from Princeton University Press, 3175 Princeton Pike, Lawrenceville, NJ 08648) \$8.00.

Against the background of President Bush's "school readiness" education goal, Ernest L. Boyer, President of The Carnegie Foundation for the Advancement of Teaching, proposes a seven-step strategy to ensure

learning readiness for all the nation's children. The steps are:

1. **A healthy start**—including increased funding for existing maternal and child health and nutrition programs;
2. **Empowered parents**—including parent education, particularly about language development, and preschool PTAs;
3. **Quality preschool**—including designation of Head Start as an entitlement and more stringent licensing requirements for child care centers;
4. **A responsive workplace**—including provision by all employers of at least 12 weeks of unpaid leave for parents of newborn or adopted children;
5. **Television as teacher**—including a Ready-to-Learn cable channel and at least one hour of preschool educational programming per week on each of the major commercial networks;
6. **Neighborhoods for learning**—including a network of well-designed outdoor and indoor parks in every community and a Ready-to-Learn Center in every major shopping mall; and
7. **Connections across the generations**—including participation by older people as mentors in day care centers and preschools.

Today's Children: Creating a Future for a Generation in Crisis (1992) - David A. Hamburg, M.D. (Times Books, a division of Random House, Inc., New York, NY 10022) \$25.00.

In his introduction to this volume, David A. Hamburg, M.D., President of the Carnegie Corporation, notes that the general outlook of his work can be expressed in a few sentences:

What people experience early in life provides the basis for all the rest. The early years can build the foundation for a long, healthy life characterized by sociability and learning. Health and education are closely linked in the development of vigorous, skillful, adaptable young people. Investments in health and education can be guided by research in biomedical and behavioral sciences in ways likely to prevent much of the damage now being done to children and adolescents (p. 15).

Hamburg sees early childhood and early adolescence as developmental periods that provide exceptional opportunities to intervene in ways that have lifelong positive impacts. For the early years, he calls for a continuum of services including enriched prenatal care, preventive pediatric care in infancy, high quality day care, parent education, and social supports.

Hamburg identifies five basic qualities needed by parents: 1) the ability to *nurture*; 2) the capacity to *love*; 3) the readiness to *enjoy*; 4) a passion for *teaching*; and 5) the ability to *cope*. He advocates expansion and ongoing evaluation of parent education and family support programs that include enduring relationships between intervenors and parents of young children. Calling for

combining "the strength of informal and inclusive social-support networks with organized intellectual discipline," Hamburg proposes a "rolling reassessment" of existing knowledge about early development, adapted and disseminated to parents and front-line practitioners through a variety of media and information sources.

Pathways to Self-Sufficiency for Two Generations: Designing Welfare-to-Work Programs That Strengthen Families and Benefit Children (1992) - Sheila Smith, Susan Blank, and Ray Collins (Foundation for Child Development, 345 East 46th Street, Room 700, New York, NY 10017) Free of charge.

Programs for welfare-dependent families have focused traditionally on either adult employment needs or on parenting and child development. A two-generation intervention integrates services to address both these sets of needs. It provides immediate supports for children's development, such as high quality child care and preventive health services, and also works to enhance parental education, employability and income that can sustain children's early gains. This report, written for decisionmakers, program managers, and advocates, presents a description of the basic elements of a two-generation intervention and options for program design; profiles of eight current efforts to deliver two-generation services under the Family Support Act; and sources of information and technical assistance.

The report identifies six basic elements of a two-generation intervention: 1) assessment of child and family needs; 2) high quality child care and early childhood education; 3) services that strengthen parenting; 4) preventive health services for children and parents; 5) self-sufficiency services leading to employment and a living wage; and 6) case management. The report also offers a set of indicators to use in assessing the capacity of a community's JOBS program (or network of services) to support children's health, development, and prospects for school success and future self-sufficiency.

Vanishing Dreams: The Economic Plight of America's Young Families (1992) - Clifford M. Johnson, Andrew M. Sum, and James D. Weill (Children's Defense Fund, 122 C Street, N.W., Washington, D.C. 20001) \$5.50.

According to this report, the median income of young families—those headed by someone younger than 30—decreased by 32 percent between 1973 and 1990, with the greatest part of these income losses occurring during the 1980s. In contrast, the median income of families without children increased by 11 percent during the same period. The poverty rate for children in young families doubled in young white families, young married-couple families, and young families headed by high school graduates, as well as among more vulnerable groups. The overall poverty rate for children in young families increased from 20 percent in 1973 to 40 percent in 1990. Nearly three-fourths of the increase in the number of young families with children living in poverty has occurred outside the nation's central cities.

The report recommends as immediate steps: enactment of a refundable children's tax credit; creation of a child

support assurance system; health insurance coverage and access; and full funding of Head Start.

Raised in East Urban: Child Care Changes in a Working Class Community (1991) - Caroline Zinsser (Teachers College Press, 1234 Amsterdam Avenue, New York, NY 10027) \$17.95.

This study used an ethnographic approach to examine child care arrangements in one community, with the hope that using a relatively small, circumscribed social setting as a case study would provide insights useful to the development of child care policy and shed light on far-reaching concerns about caring for children in a post-industrial society. During 7 months of fieldwork, Zinsser completed 50 formal interviews with community representatives, parents, and caregivers; formal interviews were supplemented by many informal conversations.

The overall view of one city's child care that emerged from Zinsser's study is

not horizontally stratified, with a small supply of licensed, high quality care at the top and a preponderance of nonregulated, low quality care at the bottom. The picture is more complex and of interlocking parts, with children variously cared for by parents, relatives, neighbors, babysitters, centers, and preschools in overlapping and ever changing patterns that are responsive to children's ages, family circumstances, individual preferences, and what is available and affordable.

Zinsser concludes that no one model of child care will answer the needs of all families; child care policy must be responsive to the wide variation in what parents need and want. She recommends: 1) that government funding support quality child care no matter what its auspices—whether by relatives, by well-known and trusted neighbors, by regulated family day care providers, or by licensed day care centers; 2) that regulated family day care be encouraged and supported, with sensitivity to cultural differences and family values; and 3) that licensed child care centers be upgraded and expanded, with encouragement of a mix of subsidized and paying parents and provision for a career ladder progression for caregivers.

Infants and Toddlers: A Resource Guide for Practitioners (1992) - Michael Bender and Carol Ann Baglin, editors (Singular Publishing Group, Inc. 4284 41st Street, San Diego, CA 92105-1197) \$29.95.

This volume was conceptualized to serve as a resource for individuals newly entering the field of early intervention, as well as for practitioners already working in agencies or provider systems. Written by clinicians, professionals, and parents, the eight chapters discuss the individualized family service plan process, mental health needs of infants and their families, cultural and economic diversity, service coordination, empowering the family, training of practitioners, implementing early intervention in child care settings, and managing interagency resources. Contributors include Noma Anderson, Carol Ann Baglin,

Michael Bender, Nancy Donohue Colletta, Michael Gilbert, Barbara Hanft, Susan Hochberg, Lemmietta McNeilly, William Sciarillo, Janeen Taylor, and Deborah Von Rembow.

Toddlers and Their Mothers: A Study in Early Personality Development (1992) - Erna Furman (International Universities Press, 59 Boston Post Road, Madison, CT 06443-1524) \$49.50.

"For those who enjoy it," notes Erna Furman, "living and working with toddlers provides special satisfactions, among them the opportunity to enter, or reenter, a world of experience so different from that of the older child and adult; to understand maternal functioning at a time when it still constitutes an integral part of the child's personality; to assist the mother-child couple in negotiating this crucial developmental phase; and to learn about its impact on later development." This volume describes the Cleveland, Ohio Hanna Perkins Therapeutic School's Toddler Group setting, its educational curriculum, and its treatment-via-the-parents. The book introduces the Toddler Profile, a research tool for assessing all aspects of the child's personality as well the parents' relationship with and handling of the child. Findings that have emerged from work with toddlers and parents are described, in areas that include bodily self-care, growth of personality functions and feelings, play, and early inner conflict and defenses. The transition of Toddler Group "graduates" into nursery school is also reported.

Furman discusses a variety of mechanisms that she and her colleagues have used to share their findings with parents and professionals. These include publications, workshops, and an ongoing Working with Toddlers course that emphasizes the discussion of clinical material, with general concepts integrated into the discussion.

Call for papers

The American Statistical Association will hold its winter conference January 3-5, 1993 in Ft. Lauderdale, Florida, on the theme "Families and Children: Research Findings, Data Needs, and Survey Issues." Sessions will address research and statistical issues concerning families and children at all life stages and in all configurations, with attention to health, education, family structure, and economic well-being. Contributed paper submissions must be postmarked by **August 15, 1992**. For information, contact American Statistical Association, 1429 Duke Street, Alexandria, VA 22314-3402, tel: (703) 684-1221, Fax: (703) 684-2036.

Conference Call:

August, 1992

August 8-12: The Federal Interagency Coordinating Council will sponsor the Partnerships for Progress conference, addressing aspects of the Individuals with Disabilities Education Act, in Arlington, Virginia. For information, write to Meme Holt, 500 Nationsbank Plaza, CB 8040, Chapel Hill, NC 27514-8040.

August 10-14: *Contemporary Forums* will sponsor a conference on "Perinatal Dilemmas," designed for physicians and nurses, in Jackson Hole, Wyoming. Contact Contemporary Forums, 11900 Silvergate Drive, Suite A, Dublin, CA 94568, tel: (510) 828-7100.

August 25-28: The Infant-Parent Institute of Champaign, Illinois will offer the 12th annual Brief Summer Course in Infant Mental Health. Principal Instructor will be Michael Trout, Director of the Institute. Write or call Michael Trout, The Infant-Parent Institute, 328 North Neil, Champaign, IL 61820, tel: (217) 352-4060.

August 30-September 2: The International Society for Prevention of Child Abuse and Neglect will hold its 9th international conference in Chicago, Illinois, with the theme "An International Commitment to Prevent Child Abuse." For information, contact Congress Headquarters, c/o Moorevents, 676 N. St. Clair, suite 1765, Chicago, IL 60611, tel: (312) 951-9600.

September, 1992

September 9-13: The World Association of Infant Psychiatry and Allied Disciplines will hold its Fifth World Congress in Chicago, Illinois, on the theme "A Future for Babies: Opportunities and Obstacles." Contact Jo Cohn Sawyer, 2 N. LaSalle, Suite 605, Chicago, IL 60602-3703, tel: (312) 621 0670, Fax: (312) 621-0377.

September 12-14: Mary Washington Hospital and the Infant Development Education Association will sponsor four seminars on infant development based on the curriculum developed by Susan M. Ludington. For information, call Cathy Thompson, (703) 899-1236 (daytime/answering machine) or (703) 899-1100, Beeper 400.

September 17-19: The National Black Child Development Institute will hold its 22nd annual conference, entitled "Our Children: Miles To Go, Promises To Keep," in Washington, D.C. Write or call Vicki Pinkston, NBCDI, 1023 15th Street, N.W., Suite 600, Washington, DC 20005, tel: (202) 387-1281.

September 21-23: The National Association for Regulatory Administration will hold its 1992 Licensing Seminar, entitled "Excellence in Human Services Licensing: Challenges for the Future," in Raleigh, North Carolina. The seminar will include topics and courses appropriate for licensing staff in child day care licensing and child welfare, among other areas. For information, contact Nancy H. Brown, 620 Poe Hall, North Carolina State University, Raleigh, NC 27695-7801, tel: (919) 515-3127, Fax: (919) 515-7634.

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This index groups by topic the articles and review of publications that have appeared in *Zero to Three* from September, 1991 through June, 1992. When an item is listed as "review of" this means that a brief summary of the publication appears in the issue of *Zero to Three* indicated.

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